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Original Article.

MOTIVE, PREPARATION AND RE- SULTS IN ABDOMINAL AND PELVIC SURGERY.

By JOSEPH PRICE, A. M., M. D.,

My motive in coming here is not so much to impart as to gain information. I know the value of contact, of close and intimate association with the zealous working men of the profession. Our talks, generally, have much that is very crude in them for which we need not pause to apologize.

There is a growing conviction in the profession that every surgeon must stand on his own legs. In medicine and surgery there are no Blue Laws—no geography fixing the limits of advances. There will always be a pressing need to make our science and art better. There is not much in that physician or surgeon who is content with his little store of scientific knowledge, with the results of his observations and experiences however extended and successful. He would serve better in redeeming some old sedge field to productive agriculture than in the field of medicine and surgery. Those men learn most who feel most the gravity of their responsibilities, the issues involved in their work; and who zealously seek through every avenue of observation, investigation and research for that knowledge and art, those combined agencies, which will make their work the more successful.

Many of our countrymen travel from the extreme borders of our forty-four commonwealths to our medical centres for the lessons they can gain in laboratories, hospitals, and public and private clinics. This spirit of improvement promises much for the future of medicine and surgery. It would be very

discouraging to feel that our present surgery could not be out-done. The tendency is to break away from all traditions, rules-of-the-thumb maxims,—to drop all reverence for fossil immutability, for medical antiquities, the bric-brac and mummies of ancestral chimney corners,—the preference is rather to do with that which is alive and promises life than with a carcass.

It is growing to be better recognized that the clearness with which the surgeon sees, the skill with which he works must come of accumulated experiences. We have a rapidly growing army of laboratory workers whose researches are making rich contributions to modern science, many of the men working with all the enthusiasm and energy of the old chemists. There is more grit and energy in the young of the profession than has ever characterized any previous period in the history of the profession. The old veterans are along with them with a youthful warmth of fellowship, and there is nerve and inspiration in their elbow touch. Wide series of researches have been called into life, directed by many along specific lines, and the more specialistic press upon our notice. These researches are evolving definite ideas from conflicting theories. So many are the kinds of work and kinds of workers that the laity are puzzled where to go and to whom with their special afflictions.

In this particular there is no very special harmony of opinion among physicians. Though a life is involved their better professional judgments are often overcrowded by personal prejudice, likes or dislikes. There is not enough of clean, clear, active working of professional conscience. There is something of appropriate illustration of this spirit in the hospital science drawn by the witty German, Henry Heine: "They remind me of a revolting quarrel, in a little hospital at Cracow, of

which I chanced to be a witness, and where it was horrible to hear how the patient, mockingly reproached each other with their infirmities; how one who was wasted by consumption jeered at another who was bloated by dropy; how one laughed at another's cancer in the nose, and this one again at his neighbor's lock-jaw or squint, until at last the delirious fever-patient sprang out of bed and tore away the coverings from the wounded bodies of his companions, and nothing was to be seen but hideous misery."

Reckless ignorance, unreasoning jealousy, professional vanity, a narrow envious rivalry often goes on, insolently refusing counsel, until when the coverings are removed nothing is to be seen but hideous misery. The profession would not be impoverished by expelling all men with such low-governing motives, nor would humanity suffer.

In relation to surgery, the least experienced, the more ignorant are the ones who talk the most about the ethics of operative procedures, and even after they have failed in palliative treatment, exhausted their therapeutic resources they oppose resort to surgery. From this blindness, this narrowness, there will be an awakening. Fortunately this spirit grows beautifully less as the profession liberalizes under the influences of our advances. The notoriety of these characters renders their company of easy avoidance.

There is a certain justifiable antagonism between the honest, educated, conscientious general practitioner and the specialists of a certain class. There could not be, nor should there be, good feeling for that officious class who find fault with, and unsolicited, interfere with prescribed treatment. It is not by knowledge and skill such men sustain themselves, but by artifice, by undermining more worthy and better men. To them medicine and surgery are not learned, high-toned, dignified professions—but trades, marts, into which they can go with their wares and practice their damaging acts for the little, or much ready cash, they can command; their only credentials to recognition are their audacity and insolence.

The professional spirit of the period is not one of mimicry. It is not mortgaged to old ideas and methods. Innovations are welcomed; that only is accepted as tested

truth which has withstood the severest processes of verification. We honor the man who confronts us with an honest difference of opinion; he may have much for us we need to know. I will greet him as my hero friend, if he, with his better light, will supplant my methods with his better ones, and I would have my patients send him greeting.

Both in medicine and surgery the line between enough and too much is becoming better understood. It is realized that the physician's resources are exhaustless—that they are co-extensive with the limitless field of medical science; that the highest honor of the profession is the cumulative culture, refinement and success of its individual members; that every growth and success of the individual physician is the honest advantage of all. We all must feel again and again the pain and mortification of imperfect work. We prefer to take the great workers, those working unremittently to master the puzzling problems, as types or representatives of the best spirit of the profession.

There may be some barriers to the free use of some of our educational agencies, but they *can* and *will* be broken down. We will have more free, liberal and better teaching within the walls of our public hospitals, where ministers our public and private charities to the unfortunate victims of accident and disease; from their bed-sides we *will have* the lessons that will advance our science and improve our art. We *will* batter at the doors until they *open*, or *down*, and let us in. The spirit that will gladly welcome will be substituted for the narrow and selfish one that bars us out. We are entitled to be present witnesses of those maladies with which it is our life mission to deal. There general practitioners can gain valuable lessons,—and it is in their ranks every successful specialist in the profession must have his beginning,—and there the honest, enthusiastic student of a specialism can the more thoroughly equip himself for his work.

Where the specialist in gynecology, or in any special line of surgery, attempts to give practical training it will be used against him by his professional rivals, who will try to secure patients by saying to them, "If you go to Dr. Blank he will have his students do the operation; he won't do it himself." This fact operates against practical training in private hospi-

tals. But no such excuse exists against such training in public or general hospitals. The thorough education of physicians, the health and happiness of multitudes of unfortunate human beings, demand that the lessons of the operating table and bed-sides of these institutions should be the privilege of every physician and surgeon. That man does the most effective teaching who does it with his apron on. We cannot multiply to too great an extent the avenues through which we can obtain the highest education in our science, in the methods of the best surgical procedures, in the refinements of their technique. From every patient we attend there comes to us the urgent bidding, "give us the benefit of your best science, your most perfected methods for our healing."

I would press these facts home, for it is the voice of the profession that will bring about this important gain in our educational facilities. By the rights of that humanity it is our high duty to serve, I have a right to the benefit of what you know and you have a right to the lessons of my experiences, down to the simplest teachings of the cunning of my fingers.

A little aside from logical connection I would say that there is no self-mortification or shame in recognizing our individual professional limitations. When a member of my own family is sick, an early experience in general practice enables me to detect symptoms and locate the trouble, but I am prompt to call in a physician of known reputation for the treatment, an expert in the peculiar trouble, and the case is left as absolutely to him for treatment, as I insist upon in cases coming into my hands for surgical treatment. We can only stand, professionally, on the highest elevation when all the purely selfish elements are eliminated.

The inevitable risk in all cases, is that while the physician is being whirled around in a circle of doubts, symptoms are augmenting, the disease becoming more aggravated and the chances of relieving suffering and saving life growing less. Happily the profession is growing alive to these facts.

We are forced to keep in advance of the intelligence coming out from our free schools—I don't like the word common. Our clientele is demanding more and better work than was ever

before demanded. Our specialisms are largely an outgrowth of this demand. In many instances the general practitioner tires of an extended and exacting practice, as he finds it wears upon his vitality. Necessity presses upon him to restrict its limits and he turns to some speciality in which his tastes and aptitudes promise success. Combining the training of his general experience with a careful and thorough training in the speciality of his selection, successful work is assured. He will hold high and honored place in his speciality—will make a record, and that not of a startling mortality. Not so with that noble possibility in embryo, the fresh graduate from our colleges, with his fashionable droop of the shoulders, bend of the elbows and knock of knees, and his one glove, who, immediately on receiving his diploma, essays to enter these fields with only his superficial theoretical knowledge, while he is scarcely prepared to do general work.

The need of the student is a hospital training, followed by dispensary practice, where he will become familiar with physical examinations and learn to recognize disease with varied forms. No one has a right to attempt the treatment of the diseases of women until he is educated to recognize and differentiate them.

Women would be better off if some of the so-called minor gynecological procedures had never been devised. Some operations and instruments in the hands of inexperienced and ill-trained hands are doing thrice more harm than good. It is alarming to note the number of serious major gynecological operations following closure or dilatation of cervix, also the inconsiderate use of the curette in the presence of advanced tubal and ovarian disease, or for the fancied existence of intra-uterine troubles, or as a therapeutic measure for a trouble lying beyond and unrecognized.

If it were possible to ascertain all the images called up to the inexperienced by the term abdominal surgery we would have a medley of conceptions as to such operations. The layman's views are very horrifying to him—to the poor woman, with whom we have to directly deal, they are not less so. We approach them, not with timidity, for that is not an element in the character of the surgeon, but with a very keen appreciation of the weighty responsibility involved, with a quick sense of the profes-

sional conscience, surgical judgment and skill needed to deal with those calamitous troubles to which women are subject. The woman, in the major cases, comes to us and uncovers "her hideous misery"—one perhaps concealed for years from a morbid sense of delicacy, or yet more likely and more frequently occurring where radical remedial treatment has been delayed through the tinkering and counsel of the attending physician. The specialist is very often her last resort. She goes to him in her desperation with her special trouble, when suffering has rendered her useless, life scarcely worth living, general health broken, weighed down by fears and many painful disappointments; with but one feeble hope clinging by delicate thread to precarious conditions. And then as she lies prostrate, disarmed, helpless, under our anæsthesia, there goes out from her a mute appeal to the highest motive that can govern in our surgery. It is, that by all the sanctities, there shall, unselfishly and devotedly, be rendered her the best service of trained judgments and skilled hands.

To be fit for this work the surgeon should clearly recognize the possible complex conditions lying concealed. His understanding of the organism of the parts with which he deals and their functions should be as nearly perfect as lies within human limitations, and this is possible only to the one who patiently investigates until he finds the truth. The great old scientist, Agassiz, could by a bone, detect a fish belonging to an extinct species; his thorough knowledge of the organic structure enabled him to know the parts.

In abdominal surgery, in fact in all surgery, there are important requirements and conditions auxiliary to judicious surgical treatment and success. The utmost care should be exercised in making all the patients' surroundings, in minutest detail, the very best. There should be cleanliness from the cellar floors to the escape pipe in the roof. There is no chemistry that will prevail against uncleanness and slovenliness either in person or surroundings. Cleanliness, ventilation and dryness are the proper deodorizers of houses. The best precaution against all forms of dirt and dust collection is water, soap, brush, will and muscle. Their free and unremitting use, are the sure anti-

septic against filth infections. Impure water is a sure conveyance of infectious poisons into the human body. All about there should be an atmosphere of purity, simplicity and cheerfulness. There is something very depressing, even to the well and healthy, in the gloom of surroundings. These sanitary and other precautions will not be carried out except under the most rigid surveillance of the surgeon himself. I presume I am not as well up in the Bible as my friends of Missouri and Kansas, but I thoroughly believe, indeed, know that the truth of the scriptural injunction, "Cleanliness is next to Godliness," is confirmed by the logic of every surgeon's experience. We insist upon the perfection of arrangements of sewerage, and scavenger, and a pure water supply for the prevention of filth diseases, while we often have offensive matter on or about our persons which water, soap and brush would remove. I would start with cleanliness, keep it up and end with it in my practice in obstetrics and in your practice. My practice in surgery and your practice, general or special, is worse than useless without it.

It is difficult to impress upon local sanitary authorities the terrible consequences of filth infections. It is sometimes only the noise of the dead carts and the activity of undertakers that awakes them to activity. It is only when filth diseases become mythically epidemic that they so far forget their despicable local politics as to pay attention to those sanitary matters which concern the welfare of the entire community in which they live and of which they are part. The continuous inflow into office receives more attention at their hands, than the continuous outflow of decaying refuse and infectious matters. The effect of such criminal neglect can not be represented in numbers, the diseased are not reckoned in the long roll of mortality.

The nurse should be the very impersonation and perfection of cleanliness, and not an animated lump of dirt and grease; she should be intelligent, quick and full of resource in emergencies; cheerful and amiable of disposition, not inclined to depression and moping. She should not be in love, except with her work. She should have great tact in dealing with patients, be quick to detect and adapt herself to peculiarities of dispo-

sition, even to those of the congenital shrew, combining with all great decision, coolness, nerve, kindness and gentleness. The expert, trustworthy and pains-taking nurse is invaluable to the surgeon; she relieves him of many anxieties and multiplies the chances of the patients recovery.

This rigid regime carried into our obstetrics would secure better general results than have heretofore been secured. The standard of proficiency of those attending through the critical period of child-bed cannot be made too high. We all know the damage and suffering caused by ignorance at this period. Ignorance nor any form of uncleanness should be tolerated within the sacred precincts of the child-bed chamber. These cases are often trusted to the care of women without the slightest education or preparation for this all important work, often women who are not capable of deciding in any given case whether the labor is natural or otherwise. Knowing the sequela, the terrible results of the ignorance of midwives, we take the high ground that mother and child should have the benefit of a trained nurse where such is possible, and of an experienced practitioner and obstetrician.

It, perhaps, is fortunate for us that we have no record of the terrible mortality of midwives—of the death and desolation their ignorance has carried into homes. In obstetrics our mortality should be about *nil*. I will refrain from discussing any of the muted questions in obstetrical practice. In the language of the grand old autocrat of the profession: "No man makes a quarrel with me over the counterpane that covers a mother with her new-born infant at her breast," and there may be something prophetic in his strong words that in a near future an enlightened public will have a "grand jury to bring in a bill against a physician who switches off a score of women, one after another along his private track, when he knows that there is a black gulf at the end of it, down which they are to plunge, while the great highway is clear."

There is one peculiar species of nurses I would not recommend to your favor. I would not recommend the selection, as nurse, of one who approaches the bedside and, gently stroking the patient's forehead, says, "My dear allow me to soothe your pathway to the grave. It would make me

very happy to deliver any little last messages you may desire to leave behind for your friends. I hope you have arranged matters so as to feel reconciled to go." A nurse of this character exercises a rather melancholy influence. Too large a corps of nurses tends to confusion and is not favorable to good work. The number in attendance upon the operator should be limited to two, with perfect knowledge of his methods, and alert in anticipation of all his wants, and at no time should there be shadow of varying from his directions.

The most scrupulous care should be exercised in preparation of the patient for operation. One solution of the distressing mortality, following the work of some men, comes of careless preparation of the patient and neglected or bad nursing and after treatment.

Commonly the treatment begins in opium and stimulants and ends in opium and stimulants and a death certificate. Unfortunately some men are still at work using opium and condemning the use of the drainage tube. Comparing the crude imperfect methods of early operators we have a very satisfactory explanation of the causes of their startling mortality. Early in the history of ovariectomy the mortality ranged from twenty-four to seventy per cent.; now it varies from *nil*, in the hands of a few operators, to fifteen per cent. Careful and thorough preparation and qualification for this work, improvement and refinement in methods, accounts for this very marked reduction of mortality. Those with the highest percentage of mortality are of that class who began the study and practice of their surgery in the peritoneal cavity, with no other preliminary experience, probably, than that of having vaccinated a baby, and without that varied practical knowledge of general surgery essential to success in this special line.

To the inquiry, who should do abdominal work, there can be but one answer: The one who has served an apprenticeship and who knows where, when and how. The study of methods and technique by those ambitious to enter the field of gynecology, does not receive that attention its importance demands. It is approaching close to the end of a century since the first ovariectomy was done; the methods and technique then were about the same as now; the procedure nearly as

perfect, and now it may be regarded as established. Then, as now, the pedicle was ligated and dropped. A number of American operators use the ligature and drop the pedicle. Dunlap, of Ohio, never used the clamps in a long series of operations.

The man who attempts this work should be quick, yet of deliberate decision. There should be no vibrating between conflicting opinions. He should possess skill of manipulation—a finger education. He should have a clear knowledge of planes of cleavage to be followed in enucleations. In these operations there should be no dancing about in uncertain efforts; a studied procedure will give a wealth of resource to fall back upon while dealing with troubles uncertain in character, relation and fixation to adjacent visera.

Surgery is not one of the dilettante sciences, nor one of rude medicinal art. It is best illustrated by masterly, civil engineering.

I will pass, in hurried and brief review, a few of our procedures. To do hysterectomy successfully, it is, first, of vital importance to learn how to make a pedicle. Second, how to treat it after it has been made. This once understood, the operator will have but little trouble with his patients and but few deaths. In a series of one hundred hysterectomies I lost six, three malignant and hopeless; two were pyæmic long before the operation, and one I lost by bad surgery. I will not here go into the history of treatment of the pedicle.

The removal of a simple cystoma is one of the simplest of operations in surgery, a short incision, withdrawal of fluid, and sac; tying the pedicle and closure of incision by a few sutures, is a safe and simple procedure. But the removal of adherent or ruptured cystoma, or a suppurating cystoma with a twisted pedicle, a suppurating dermoid with universal adhesions, require some surgical judgement and skill. This complicated group requires painstaking enucleation for separation of all adhesions, careful examination and repair of all adherent and injured viscera. In suppurating forms of pelvic and abdominal disorders, the adhesions and complications are all more marked and requires manipulation, careful and painstaking toilet.

In hysterectomy we are divided into two camps, some practicing the super-vaginal amputation, with the extra peritoneal fixation of the stump which gives the best re-

sults; others practice complete extirpation or amputation by the flap methods and dropping the stump; the mortality in both operations remains high, but there are some operators working with a low mortality by the extirpation method. The surgery of hard tumors is not so serious and difficult as heretofore imagined. It is true there is a great deal of surgery in the removal of a large fibroid, but if healthy and non-adherent it is a safe and easy operation. The removal of a healthy tumor from a healthy peritoneal cavity, the pedicle made small and fixed in the lower angle of the incision, is one of the safest of major operations. Some of the large, complicated tumors require incision and retraction of the capsule anteriorly.

Small tumors are just as dangerous as large ones in a majority of cases. In the first place, if they are left alone they often become big, and in the second place, the shape of the tumor often does more to determine its dangerousness than mere size. In fibroid tumors of the uterus fantastic features in shape are often present, and the irregularity of contour may cause a comparatively small tumor to encroach in this direction or that upon organs which, if it were symmetrical, would not be interfered with at all. Shape, then, is a great determining feature in the ease or difficulty with which a fibroid growth may be removed. If it is irregular its irregularity will give less trouble when it is small than when its size is considerable. In addition to this, it is a feature that runs into time and extent of operation. It is rather surprising now to note the frequency with which fibroid tumors occur, and these of a dangerous type. It is surprising how many of these tumors are found among the better classes, where for a long time the woman will suffer in silence and finally only disclose her trouble after the growth is considerable. Here, too, the tumor itself often is not regarded, only the mischief it has caused. Edema, pain, pressure upon the bladder or intestines or upon the diaphragm, may, alone or together, have rendered life miserable, and the poor sufferer is no longer able to hide her pain and discomfort. What I wish here to insist upon is that in this respect so far as causing complications is concerned—the small tumor is just as apt to figure as a determining factor as the large. If the tumor is a regular, symmetrical one the compli-

cations are apt to come on late; if it is small and nodular, irregularly filling up the pelvis and abdomen, the complications grow apace with its irregularity and the bias of its nodosities, and there is no saying when the symptoms may become suddenly urgent. Combined hard and soft tumors are by no means rare. They are apt to give rise to a good deal of difficulty in diagnosis. Fluctuation may not be present in the fluid portion, but only a peculiar resiliency, while the hard mass in connection with the elastic one may simulate to some extent a pregnancy. Indeed, here we come to a real condition, not a theory. In many cases where the Porro operation is indicated this is the very state of things found. We have a hard tumor or a number of them blocking up the pelvis or extending above the pelvic brim, thus interfering with the delivery of the child. If the woman has gone on to quickening the complication can be readily recognized; but if in the early months, or with a dead fetus, we are put to our wits' end to explain the situation, especially if the tumor has been of rapid growth, concomitant with pregnancy, and never before noticed. In such cases the minutest history must be gotten, and this, in connection with all subjective and objective signs, help us to a diagnosis.

One of the most common complications to be expected with fibroid growths is the dermoid cyst. This peculiar tumor is always an unpleasant complication of any condition alongside of which it may be found. It is uncertain in its nature, painful in character, apt to be complicated in its adhesions, its contents irritating, sometimes offensive; when this is the case the utmost caution must be used to avoid infection.

Tubal disease in the presence of fibroids is most common. This is to be taken into consideration when it is argued that a fibroid can be treated *per se* without resort to surgery. Now, in relation with all fibroids identical tubal disease does not occur. There may be simple inflammatory disease, or there may be hydro-salpinx, or there may be a true pus tube, or a combination of any two of these. What we are to remember—and this cannot be too strongly insisted upon—is that the danger of the existing complications may be paramount, in its way, to the danger of the fibroid itself. None of these tubal conditions, with all that this implies, are

remediable save by direct interference, as the surgeon finds them. As to what the theorist has to say about them I do not much care.

All fibroid growths are to be watched carefully for malignancy. This is not to be lost sight of under any circumstances. If we attempt to lull ourselves into repose by imagining a tumor entirely benign, we shall often be deceived in the sequence.

Another complication of the fibroid is the irreducible ovarian cyst. Here we may infer that the two masses are one, and, if the error is not early corrected, we shall have the serious misfortune before us of attempting to include an ovarian cyst and a fibroid tumor in one neud. I have in mind a neophyte who, after seeing a fibroid removed by the extraperitoneal method, a day after followed the same technique with an ovarian cyst! Such is the demonstration of surgery to too many lookers-on.

Another altogether different condition, which may puzzle the acutest diagnostician, is a tumor of the kidney crowding itself down upon the uterus. Here the commonest manifestations of fibroid tumor of the uterus are present edema, emaciation, irregular bleeding from the weakened condition of the patient. The uterus cannot be separated from the tumor, and on combined palpation resists and falls with it. In such a condition it is easy to see how any lack of surgical resource is fatal to both patient and operator, and how different is the condition to be dealt with from what has been anticipated.

Bearing in mind the rapidity with which some forms of myomata develop, it is again evident that a thick-walled ectopic sac may simulate one of these tumors.

As I have already said, there has not been, and there is not yet, a consensus of opinion in reference to the best method of removing these growths. The objections to the clamp—the instrument that has given us the best results—are, I consider, puerile. The ideal method is that which gives the best results, aside from the inherent beauty of its conception and execution.

Of the many operations and modifications proposed for the removal of the fibroid uterus, there is need of here considering but three—to wit, the operation by the clamp or *serre-neud*; the operation for the removal of the entire uterus; and that of stitching the peritoneum across from side to side, leaving the crevix open

in order to allow the escape of pus and ligatures in a few days. Of this latter operation it is only fair to say that the results have been apparently good, but that it is good surgery, or more ideal than the use of the clamp, to do an operation with the expectation of pus to escape from the vagina, is not at all to my understanding.

As to drugs, the growth of tumors is not affected by their use, electricity aggravates them, complicates symptoms, multiplies the difficulties and augments the risks of surgical procedure.

From my experience I feel the importance of urging promptitude in all abdominal and pelvic troubles; of early ovariectomy; of educating the entire profession up to the importance of early recognition and early removal of cystoma; of the early removal of the appendages for fibroid growths; early removal of large and rapidly growing hard tumors, of tubal pregnancy ruptured or unruptured; the early removal of all suppurating forms of tubal and ovarian disease,—*actual, not fancied disease*.

It is important that every member of the general profession in active practice should be able to recognize any and all these troubles. When such becomes a fact of the profession at large an innumerable number of women will be saved untold, unguessed affliction and misery. We have a large and constantly enlarging need and the field of work is immense, and the energy and industry with which it is cultivated should be *correspondingly immense*.

The clinic makes accessible many primary truths and casts a rich light on many difficult problems.

As for myself, so supremely, so profoundly do I feel the great importance of our work, its far-reaching concern, that I would rather by continuous, unrelaxing effort crowd into a few year's that mastery which would crown my work with something prophetic, at least, of its possibilities; a crown into which I would have threaded the lesson that our skill, our refinements and our successes must come of intelligent, tireless application, unselfish devotion and generous co-operation; this, rather than a century of human existence tinkering with the afflictions of the mothers of our race. And in this I am happy in the consciousness that the hearts of many of the Fellows of my Profession beat time with mine.

SPECIALISM, AND THE INSANE.

By MARIE B. WERNER, M. D.
PHILADELPHIA.

The close relations which physical suffering bears to the mental emotions is shown daily, and recognized. Acute suffering produces a train of symptoms which pass off promptly after the cause is removed. Chronic suffering, on the other hand, will often undermine the nervous system to such an extent, that a previously equable temperament may give way to one of an irritable and excitable character.

The fact, so often met with in practice, of the continued nagging pain induced by chronic inflammation, and which produces in some a state of nervous excitability, frequently hard to combat, unless measures are taken to remove the source of irritation, will not be disputed. Such experiences have led to more careful investigations and researches in all the various special branches, and we have to-day the oculist aiding the neurologist in not only studying each case, but also aiding and directing cures, before deemed impossible. The surgeon's knife and trephine has achieved results, of which we can all be justly proud, in cases of epilepsy caused by trauma, or in idiocy induced by the general compression of the contents of a prematurely ossified skull. These special studies are the arms which gather in the suffering and needy to afford help and to make the body of the profession stronger. Another arm has been reached out in the last few years, but unfortunately has been misunderstood by many: Gynecology, in its recent progress, has opened up many avenues for the cure of ills that were for a long time unrecognized in their entirety. Many have expressed themselves unfavorably, maintaining that extreme measures are resorted to more often than actually called for. Let us take an impartial view of this matter, confining ourselves only to those cases where *actual disease* can be demonstrated.

How often has the practitioner of long experience seen certain theories arise and die out after a time? Was that not because they had not sufficient foundation to live? "Truth remains, though the heavens fall." Who would think of allowing an abscess to burrow in loose structures, when an incision and well directed treatment will arrest the mischief and save the

patient from blood poisoning? Is there a surgeon who would hesitate to resort to the knife in any case, where, say gangrene or tuberculosis of any limb threatens life? Why should disease out of sight be treated less radically than that which can be seen? That each operator has in his early experience done some work, which he felt by knowledge gained later, he might have done better no one denies, but one cannot judge the other lest judgement fall back upon the judge. There are many hundreds who thank the surgeon's knife for the comfort they now experience, and the lives of usefulness they can lead; and many feel the bitterness of the words "too late."

Some operators, who have successfully dealt with multiple and single abscesses in the pelvic structures, which had given rise to periodic attacks of pelvic peritonitis and in consequence to vicious adhesions which alone often give rise to the most painful symptoms, have extended their influence and knowledge in the direction of that class of unfortunates, who often cannot understand or make known their sufferings, viz., the insane. Their results have on the whole been encouraging, in so far that they have removed one source of irritation, always having in mind to operate *only in cases where disease can be demonstrated beyond a doubt.*

During the summer of 1891, in a conversation with Dr. Alice Bennett, of the Norristown Asylum, I found that she considered the presence of insanity an expression of destructive changes in the nerve cells, and from that standpoint a cure becomes impossible. For that reason she discouraged investigations on this point. In April, 1892, I received Dr. Bennett's permission to begin a series of studies at the Asylum in the early part of the following May, hoping, thereby, to aid in solving the important question Can the Gynecologist aid the Alienist? And, for the benefit of those impartially interested, I will give a summary of thirty cases examined, and of two sections done on July 3rd, 1892:

CASE I. Melancholia, following last labor, vagina examined; small mass in right pelvic space; prolapsus of uterus; lacerations of cervix and perineum.

CASE II. Acute Melancholia. First attack supposed to have been induced by the establishment of puberty; second at-

tack followed third labor; uterus fixed posteriorly; mass to the left; right ovary prolapsed.

CASE III. Acute Mania. Attack sudden, in August, 1891; patient aged forty-seven; vagina examined; uterus drawn to the left; painful mass on right side; cyst of right labia; complains of pain down legs when walking.

CASE IV. Melancholia. Second attack, vagina examined; uterus antiflexed; masses both sides.

CASE V. Mania. Vagina examined; uterus retroverted and fixed; body large, cervix small; rectal examination reveals masses on both sides.

CASE VI. Melancholia. Three months after birth of child. Uterus retroverted and fixed; external hæmorrhoids.

CASE VII. Melancholia. Uterus enlarged, fixed to the left; mass on right side; cystic degeneration of cervix.

CASE VIII. Mania. Multinodular Uterus; masses on the right side with tenderness; cystic degeneration of cervix, and bleeds to touch.

CASE IX. Mania. Uterus enlarged; some impaired mobility; cervix cystic and eroded.

CASE X. Mania. Last labor occurred six months before admission. Uterus enlarged, somewhat hard; moderately movable; cervix patulous; bleeds readily.

CASE XI. Chronic Mania. Brain fever marked the onset of the attack; uterus retroverted, prolapsed and fixed; tenderness in both pelvic spaces.

CASE XII. Mania. Mass in right pelvic space; perineum lacerated.

CASE XIII. Melancholia. "Was not well after last child was born." Uterus prolapsed; laceration of cervix and perineum.

CASE XIV. Mania. Second attack; uterus fixed, masses on each side; laceration of cervix and perineum; kraurosis of both vaginal orifice and vulva.

CASE XV. Mania. Small undeveloped uterus; fundus posterior and to the left; moderately movable.

CASE XVI. Mania. Last child July 20, 1891; placed in Friend's Asylum, August 8, 1891; uterus fixed anteriorly; tubes tortuous and enlarged; left ovary cystic; laceration of both cervix and

perineum; varicose veins at vulvar orifice.

CASE XVII. Imbecility. Three children; last, four and a-half years before attack; uterus fixed posteriorly; masses on both sides; cervix patulous and lacerated; also perineum; hæmorrhoids.

CASE XVIII. Mania. Last labor thirteen months before attack, which was gradual in onset; uterus and appendages normal; marked lateral tear of vaginal wall nearly to cervical junction, causing prolapsus.

CASE XIX. Melancholia. Onset four months after last labor; uterus prolapsed and retroflexed; mass in left pelvic space; movable body in right pelvic space like the ovary.

CASE XX. Chronic Mania. Uterus atrophied; laceration of cervix and perineum; some cicatricial bands in vagina.

CASE XXI. Second attack. Atrophy of uterus; pelvic spaces free; some laceration of perineum.

CASE XXII. Melancholia. Third attack. Antiflexed enlarged, but movable uterus.

CASE XXIII. Second attack. Antiverted uterus drawn to left; mass to the right.

CASE XXIV. Melancholia. Cause puerperal; uterus enlarged and prolapsed; mass on the left; lacerated perineum; external hemorrhoids.

CASE XXV. Chronic mania. cause puerperal uterus fixed anteriorly, cervix large, body small and flabby. Tender masses in both lateral spaces; old fistulous tract to the right of the anus extending directly upward beyond the internal sphincter.

CASE XXVI. Acute mania. Second attack. Antiflexed uterus; engorged cervix and vagina; mass on right side.

CASE XXVIII. Chronic mania—pelvis of male type, vagina short, uterus undeveloped, fundus backward; cannot distinguish the appendages.

CASE XXIX. Mania. Fourth attack. Vaginal examination, uterus fixed posteriorly, tender mass on left side. Section July 3rd, 1892, removed appendages; cystoma of left ovary; right ovary undergoing calcareous degeneration; both tubes undergoing tubercular degeneration; there were some adhesions from a recent peri-

tonitis. Patient made a rapid and uninterrupted recovery; was discharged cured five weeks after the operation.

CASE XXX. Acute dementia. Admitted 1888; vaginal examination; enlarged antevverted uterus; mass on right side distinct; complains of great tenderness in left side which feels boggy. Section, July 3rd, 1892; removed appendages; hydrosalpinx of both sides; left tube degenerated to a large cyst; dense adhesions to bowel uterus and posterior-cul-de-sac. On right side tube somewhat smaller but tortuous, fimbriae of both obliterated. Used drainage thirty hours; patient made a good recovery, which I understand also includes marked mental improvement.

These cases have made me feel that there is a necessity for careful study of all cases, and especially those in which the puerperal period antedates an attack. If a remote irritation can lead to insanity or epilepsy, why cannot an abscess, tubercular disease or other pelvic inflammations, also enter the field as causative factors? The claim is not to cure by operation, but by removing the irritation and thus aiding nature in restoring, gradually, perhaps, its lost nerve force.

The presence of pain, a prominent symptom sometimes in the sane, is more often absent in the insane. This was markedly shown in a case, seen at the asylum, of probable osteo-sarcoma of the elbow of an insane patient. During the early stages of the disease, continued motion and increased excitement seemed to take the place of expressions of pain though she stoutly denied its presence. This became the more striking after the disease progressed, involving the greater portion of the arm, when she attempted to cool her arm in water and begged for a dose of magnesia.

It is impossible for the alienist to be a specialist in all branches of medicine; and it is a fact, that the insane are subject to all the diseases the sane are troubled with; hence the necessity for special work in special directions. This work however should be a conscientious painstaking study of each individual case, and the fame accruing should be based upon the products of such study and not upon the number of operations done, else the object is defeated at the beginning.

Sept. 28th, 1892.

Clinical Lecture.

THE ETIOLOGY, PATHOLOGY, AND TREATMENT OF FLAT FOOT.

By A. M. PHELPS, M. D.,

PROFESSOR OF ORTHOPEDIC SURGERY IN THE UNIVERSITY OF THE CITY OF NEW YORK AND IN THE POST-GRADUATE MEDICAL SCHOOL, AND PROFESSOR OF SURGERY IN THE UNIVERSITY OF VERMONT.

Prof. Phelps first called attention to a cast, showing hallux valgus and an absence of the arch of the foot, while the outer aspect of the foot was rotated upwards, and there was apparently a dislocation of the scaphoid bone and the head of the astragalus.

Cases of flat foot are frequently congenital and in many children, up to the third or fourth year the arch of the foot will disappear when they are standing. This is owing to the bones of the foot not having become fully ossified at this time. Hereditary influence is also often traceable in these cases. Flat foot may result from paralysis of the flexor muscles of the foot—the tibialis posticus and the long flexor—by depriving the arch of the support given it by these muscles. Occupation is an important etiological factor, as those who are compelled to stand for many hours every day in one position often suffer from a relaxation of the structures holding up the arch of the foot. Those having a tendency to flat foot will often find the condition aggravated by a change of residence from the country to the city, owing to walking on hard pavements instead of on soft earth. If in addition to this, they develop much adipose tissue, flat foot is still more likely to occur. One's manner of walking is also of importance; every person should toe inward, for, when the foot is in this position the blow is received on the outside of the foot. Savage tribes walk in this manner, but civilization has given us the walk of weakness. These are the main points in the etiology.

Exhibiting a model of a typical flat foot, he explained how a true talipes valgus would result from a still further rotation of the foot. The first change which takes place is a lengthening of the soft parts, or girders of the arch of the foot; following this comes pressure between the scaphoid bone and the neck of the astrag-

alus, and between the scaphoid bone and the internal cuneiform, which, when long continued, results in irritation and perhaps even in inflammation. Lastly there is spasm of the muscles supplying the joint with growth of new bone about the articulation, the result of pressure, precisely as is seen in lateral curvature of the spine upon the concave side of the curve.

This inflammation or irritation of the joint results in reflex spasm of the extensor muscles, chiefly of the peronei, which, if long continued, produces a true talipes valgus, together with a hallux valgus. In these cases there is always observed a lengthening of all of the soft parts in the sole of the foot.

Talipes valgus would not occur unless this pathological condition took place, which allows of dislocation downward of the scaphoid bone, the result of this unnatural lengthening of the soft parts.

Prof. Phelps exhibited drawings made from dissections to illustrate the condition of the parts. In the first one, which was taken from an extreme case of flat foot, the scaphoid bone was seen to be dislocated downward with the head of the astragalus, and a change had taken place in the articular surface of the cuboid bone. There was a growth of bone around the joint where the fibula had pressed into the os calcis. Another drawing showed the arch broken down, and the foot twisted upon itself, giving rise to a hallux valgus. He showed, by means of diagrams on the blackboard, the varying mechanical effects produced by the same force exerted upon arches of short and long curvature, and in this way explained not only the manner in which the deformity is produced, but the manner in which the remedy was to be applied.

Acting upon these mechanical principles, various appliances had been devised: Reynders puts a spring into the sole of the shoe; Dr. Royal Whitman has a plate molded over a cast of the foot, and then applied to the sole so as to hold up the arch; Thomas has suggested making the sole thicker on the inside than on the outside, thereby transmitting the weight through the cuboid bone, and so relieving the scaphoid from the pressure. Dr. Phelps had also had constructed after a German pattern, a shoe in which the patient walks upon a strap, the thickened sole on the inside of the foot everting the

foot in such a manner as to transmit the weight of the body through the cuboid, thus relieving the scaphoid bone.

These appliances are all useful in their proper place, but it is wrong to begin treatment with such instruments.

Commence the treatment by etherizing the patient, pressing up the arch of the foot, and then applying plaster-of-Paris. If the peronei tendons are much shortened, divide them, twist around the foot as much as possible, and super-arch it. This treatment should be continued for sometime, re-applying the dressings and correcting the position of the foot as often as may be necessary. When all that can reasonably be expected from this treatment has been accomplished, spring soles and similar appliances may be used.

When there is a hallux valgus, this should be at once corrected by operation, and this in itself, will sometimes cure the flat foot so far as the element of pain is concerned. Every case of flat foot is very likely to relapse, no matter what is the method of treatment adopted, unless carefully followed up and the foot kept well supported. If the foot can be placed in such a position that the weight of the body is transmitted through the cuboid bone, pressure on the inner side of the foot is relieved, and hence very little pressure will be required to hold up the arch of the foot; but if this be not done, so much pressure is brought to bear upon the springs that they cannot be tolerated. During the course of the treatment the patients should be taught to walk with the toes straight ahead, or, if possible, turned inward. They should also be instructed to strengthen the muscles about the foot by frequently raising themselves on their toes.

He does not share in the opinion of some authors that the tabialis anticus has anything to do with holding up the arch. If this muscle be paralyzed, the arch of the foot may or may not be relaxed.

Dr. Phelps then took up the question of operative treatment and presented a patient upon whom he had operated for flat foot. This young man had been treated for a number of years, but the condition had proved a most obstinate one. Almost all the usual methods had failed to give more than temporary relief.

The last operation, Bond's scarification, was performed six months ago. The

patient is now able to walk considerable distances without discomfort, and can stand ten hours a day without pain. Objection has been made to the open operation for talipes varo-equinus, on the ground that the scar was likely to be sensitive; hence it is interesting to note that in this patient the scar tissue was quite extensive and yet he can walk upon it without any pain.

Dr. Willy Myer had presented to the Academy of Medicine some very good results obtained by Trendelenburg's method of supra-malleolar osteotomy. For those patients who are not particular about the looks so long as the foot is useful, this operation is likely to prove of service.

Communications.

THE SORE NIPPLES OF NURSING MOTHERS AND HOW TO TREAT THEM.*

By P. F. ELLIS, M. D.,
BELLS, TEXAS.

Leaving the elucidation of obtuse scientific questions to others, I have selected as a subject for this essay the plain and practical one of "The Sore Nipples of Nursing Women and How to Treat Them." The title of my paper deserves the thoughtful consideration of every medical man who has one of this class of sufferers under treatment, because certain relief follows prompt treatment, while delay brings indescribable suffering and permanent injury to the mammae involved.

Finding so little in the literature of the day upon the subject, and that little found so erroneous and therefore misleading, long since I have adopted ideas of etiology and treatment of this affection which are at least original with me.

I find from experience that women who have pink-colored nipples are the chief sufferers; never having met with a case of fissured or raw nipples where those organs were dark-brown or blackish; neither have I met with a case in the Negro or Indian. Why this is so I will not undertake to say.

I deem it unnecessary to consume your

*Read before the North Texas Medical Association, Dec. 15, 1892.

time in giving the anatomy and physiological action of the milk-producing apparatus, but, that I may be the better understood further on, will say that the mammary gland is conglomerate, consists of numerous secreting follicles, grouped together in lobules, each lobule having a common excretory duct which joins those coming from adjacent parts of the gland. In this way by successive union they form the cylindrical lactiferous ducts. These ducts run a generally irregularly, straight, or curved course to immediately beneath the base of the nipple, where there is a very perceptible enlargement of the caliber of the tube (an ampulla) formed; at the outer end of the ampullæ quite a narrowing of the tube takes place, and at this narrowing many of the tubes are bent at a greater or less angle; from this angle a straight course is pursued to the extremity of the nipple where they emerge in fifteen to twenty openings for the final exit of the milk.

When the narrow point at the angle is insufficient to permit the outward flow of the glandular secretion, the ampullæ are distended, forming a kind of stricture that sometimes gives us the counter-sunk nipple.

The symptoms and signs of obstruction are: (1) the child sucks so hard as to cause the mother pain, while it frequently loosens its hold upon the nipple to fret and cry. The blood is drawn from the capillaries at the end of the nipple; (2) tender streaks extend back from the base of the nipple corresponding to the over-distended milk tube, and the lobules (or lobe rather) from which the obstructed canal leads is found to be hard and exceedingly tender to pressure; (3) we find the ineffectual sucking has denuded the end of the nipple of all or the greater part of the integument.

The over-distended lobe now takes on suppurative inflammation and nature undertakes to find an exit for the pent-up fluid by another route. The poor mother now suffers the horrors of the inquisition and frequently appeals to her medical attendant for relief in vain. The abscess forms and is lanced, or breaks, and relief speedily follows. The lobe involved is destroyed and the duct leading therefrom is obliterated. The child is taken from the breast and the nipple, or, what is left of it, heals.

The treatment to be of service must be

instituted early, that is, before suppuration proceeds too far. The earlier commenced the more certain the cure. The plan is this: On attending a woman in her first confinement, inspect the nipples before you leave her, and if they are of that delicate pinkish cast, which indicates a thin, tender skin, ask that you be informed, if, about the fourth day when the milk should begin to flow, the child sucks very hard, and if there are tender cords or lumps in her breast. If so, prepare yourself with a small magnifying glass—one such as watchmakers use—and squeezing the nipple gently so that the 15 to 20 openings for the corresponding tubes can be plainly seen, into each of these orifices introduce a fine probe and carefully follow the canal to the ampulla. When the strictured one or ones have been passed, introduce a blunt probe of larger size and more fully dilate the so-called stricture and the case is cured at once.

The operation can be done in fifteen minutes' time. It is not necessary to use an anæsthetic, and one sitting is sufficient. There is no operation within my knowledge so easily performed, or that is so satisfactory to both physician and patient.

Should the nipple have become raw and suppuration far advanced, evacuate the abscess with the knife; turn a gentle stream of water as hot as can be borne upon the nipple; dry and let the infant nurse, and then apply the water as before, except that to each pint of the water used *after* the nursing, add one drachm of boric acid; and after using the last bath, moisten one side of a pad of absorbent cotton with a solution of boro-glyceride and apply to the sore nipple. Allow the infant to suck not oftener than once every four hours, and your patient will soon be well.

ABORTION; ITS TREATMENT.*

By I. E. WEBB, M. D.,
MCKINNEY, TEXAS.

By abortion is meant the interruption of the process of gestation any time from the time of conception to the end of the fourth month. There is no condition to which a pregnant woman can be subjected

*Read before the North Texas Medical Society at Fort Worth, Texas, December 13, 1892.

that is more deleterious to her health in its immediate as well as remote effects. Abortion is a pathological process and should be dealt with as such. In studying its treatment we should first understand the condition with which we have to deal. Without going into a detailed description it will suffice to understand that the close attachment of the products of conception to the uterine wall at this stage of gestation renders it most difficult for the uterus to completely separate itself from said products because of the anatomical condition and the physiological relations.

During the earlier months of pregnancy the products of conception are more adherent to the uterine wall than at any other stage of gestation, hence, require more force for complete separation and expulsion at the time the uterus is in the most unpropitious condition for the effort. During this stage of pregnancy the increased size of the uterus is due to an hypertrophy of and increase in the cellular elements of its muscular fibres, hence, it is in a less favorable condition to contract than during the later months of pregnancy, when its increased size is due to a distention of its muscular fibres.

Nature never intended that the process of gestation should be interrupted, consequently when it is interrupted she is not so competent to carry on the process of involution as after labor at full term. The muscular fibres of the uterus during early pregnancy have not arrived at that stage of development at which the process of involution is easiest accomplished; consequently, in a case of abortion, nature is placed at a disadvantage in performing both the expulsion of the contents of the uterus and the process of involution afterwards, which is so essential to the maintenance of the woman's health. It is in assisting nature to properly perform these two functions that I wish to emphasize.

When a physician is called to a case of inevitable abortion—and it is only that class of cases that I wish to speak of in this article—his duty is two-fold: *First*, to empty the uterus of its contents as quickly as is compatible with safety to the woman; *second*, to institute after-treatment that will enable nature to accomplish perfect involution of the uterus.

In the treatment of abortion physicians are divided into two classes: *First*, those who adopt the so-called conservative treat-

ment, which consists in using a vaginal tampon, and the internal administration of ergot to control hæmorrhage and excite uterine contractions and thereby the expulsion of its contents. *Second*, those who look upon the products of conception as a foreign body, and proceed to rid the uterus of it at once, usually by means of the curette.

Two immediate dangers connected with abortion are hæmorrhage and infection. The remote danger is imperfect involution and its results. In regard to the so-called conservative treatment, the vaginal tampon is a very unsafe method of controlling hæmorrhage, and has no place in the treatment of this stage of abortion, save to lessen the anxiety of sympathizing friends, and quiet the fears of the patient.

When a case of threatened abortion has arrived at that stage where we can safely use the tampon, that is, when it has become inevitable, the os uteri is sufficiently dilated to institute a more efficient treatment. The action of ergot in these cases is questionable, for it makes the uterus contract upon, without expelling, its contents, and, should we decide to institute a more radical treatment afterwards, we will find its administration has been a disadvantage because of the contracted os uteri which it produces.

The radical treatment, or, as I consider the most conservative method, consists in introducing a Sims' vaginal speculum, and, treating the products of conception as a foreign body which in reality it is, thoroughly curetting the cavity of the uterus, especially the placental site, removing every vestige of the placenta, and then washing out the cavity of the uterus with sterilized warm water, being careful that your irrigator allows a free return of the water, and that the force of the stream is weak. The fountain syringe being always used and the stream having only a fall of 18 inches.

During the third or fourth months of gestation we may safely wait until the uterus has expelled the foetus and as much of the placenta as it can, providing there is no alarming hæmorrhage, before resorting to the use of the curette to thoroughly empty the uterine cavity. When the uterus is emptied of its contents thoroughly by means of the curette, hæmorrhage stops, the possibility of infection is nil, the uterus contracts upon itself, and is then in the best possible condition to

begin and carry out the process of involution. Ergot may succeed in emptying the uterus of the greater part of its contents, but in the majority of cases, because of its intimate attachment, there will remain some of the after-birth which is liable to decompose and infect the women, and which always prevents perfect involution, thereby producing that train of symptoms so characteristic of subinvolution, namely, prolapsus, more or less vesical tenesmus and frequent micturition, bearing down pains in the lower part of the bowels, pain in back, hips and head, more or less disturbance of the digestive organs, menorrhagia or metorrhagia, corporeal endometritis with more or less fungosities; all the result of a failure on the part of physician to thoroughly clean out the cavity of the uterus at the time of abortion and institute the proper treatment afterwards.

When we have thoroughly emptied the cavity of the uterus, I don't think our services should stop here. Nature has yet to carry on the process of involution before our patient will be well again, and, as before stated, she is not as competent to perform her work after abortion as after labor at full term. The firmer the uterus contracts upon itself the more effectually it diminishes its blood supply, and hence the more rapid and perfect the involution. By way of internal medicines to accomplish this result I think *nux vomica* and *ergot* combined give better results than any remedies with which I am acquainted, and I believe when their daily administration is kept up for five or six weeks after abortion they always prove of advantage in restoring the uterus to its normal size. A woman should maintain the recumbent position and refrain from her household duties longer after abortion than after labor at full term. As a rule she thinks "I have only had an abortion and I can get up in a few days." It is the duty of her physician to teach her better. Furthermore, I think a woman should be examined five or six weeks after abortion, and if there is any subinvolution present the *nux vomica* and *ergot* should be continued and supplemented with the boroglyceride tampon until involution is complete. If such a course is carefully pursued with our cases of abortion, I believe fewer women would to-day be in the hands of the gynecologist.

Society Reports.

THE MEDICO-CHIRURGICAL SOCIETY, OF LOUISVILLE.

Stated Meeting, Nov. 25, 1892.

THE PRESIDENT, Dr. F. S. Simpson, in the chair.

PRIMARY LATERAL SCLEROSIS.

DR. J. B. MARVIN: This patient (presenting case in person,) I saw for the first time in 1883, and incorporated his case in a report I made to the Kentucky State Medical Society, which met at Crab Orchard that year. At that time he was a student here in the Commercial College. Two years ago I saw him again at which time he entered the Baptist Theological Seminary here, where he is studying at the present time. I have not examined him since, and have only seen him once or twice in an attack that he called colic. The case is an extremely interesting one. It is not often that you can obtain as complete history and one that can be followed for several years. He has all the symptoms of lateral sclerosis; there is no history of injury, or specific cause, which would account for this transverse myelitis, and it looks more like a case of primary lateral sclerosis than I have ever before seen. Perhaps the early history of the case is best told in the patients own language.

"I noticed the first indications or symptoms of this trouble when I was fifteen years of age, at which time I was working on a farm down in Tennessee. We began our farm work early, some time in the month of January. About the middle of May I began to have a very tired feeling and would often have to sit down and rest; after sitting quietly for a half hour or so, I would get up and go on about my work but would not feel rested, especially about my limbs. Matters went on in this way until I was twenty years old. I would go to school for a few months in the year and work on the farm the balance of the time. About this time I experienced a little hesitancy in picking up my feet, but did not think anything of it, and went on working in that way until I was twenty-three; then began to use my cane a little, having greater difficulty in moving my limbs and feet, particularly in lifting my

toes from the ground. I have continued to go along in about that way until the present time. I am inclined to attribute the trouble to over-labor on the farm; if this be not the cause, then I do not know what it is. I never sustained an injury that I am aware of; have been thrown from a horse twice, but do not remember to have been injured, other than a thorough shaking up. The trouble does not seem to have progressed much, that is, since I was twenty-three years old; I can stand in one position without any tremor; it tires me more to walk than anything else. I say it has not progressed—I believe I have noticed that it hurts me more to go up the stairs, since I have been at the Theological Seminary, than it ever did before. This may be accounted for by the fact that I go up and down a great deal, and it is necessary for me to be on my feet several hours each day. I want to say this, that I am exceedingly anxious to be relieved of this trouble and would be very glad if some means could be devised to accomplish the desired end."

DR. J. B. MARVIN: When this man first came to me he had typical stiffness and rigidity of the muscles, with a tendency to contraction, and almost absolute inability to lift his toes from the ground. He had most marked tendon reflexes, as well as ankle-clonus and decided tremor. He has always had good digestion; there has been no disturbance of the bowels; no interference with the renal secretions; and he is mentally as well as he ever was. He has never had any eye or head symptoms. As far as medicine is concerned, I have told him there is nothing that would do him any good; the damage is done, this degenerative change has already taken place, and that he would have to make up his mind to be a cripple for life, so far as his legs are concerned. The trouble does not seem to affect him further than that. There is no atrophy of the muscles of the legs. The increased reflexes, rigidity and peculiar walk, make the diagnosis.

In regard to the localized lesion: the only question is, what was the cause, whether it was primary or secondary degeneration. I am inclined to the opinion that it is primary; certainly all the symptoms and history point in that direction. Authorities claim that there is no case on record in which the autopsy proved that this is a purely primary trouble, but

that it is always secondary. Of course, it is very difficult to determine whether a man has not received an injury sufficient to cause some of the symptoms present in this case, and it may be that in a fall or in his work he has sustained a strain sufficient to produce irritation in the cord—secondary degeneration. There is absolutely no history of specific trouble. He claims never to have suffered a pain of any kind in his life. Another strange feature, if this is a secondary degeneration, is that in this length of time he has not developed any head or ocular symptoms. It is not often that we have an opportunity to watch a case of this character for nearly ten years. I do not think that there can be any doubts about the diagnosis. It seems to me to be a typical case of primary lateral sclerosis

SPECIFIC LESION.

CASE NO. 2. This young man I saw for the first time this morning. You will observe he is a very strong, healthy looking individual, but in walking he uses his legs as though they were pegs, not stiff exactly, but lack flexibility. All the muscles of his legs are very hard; there is no patella reflex; legs are oedematous along the tibia and pit on pressure; there is no oedema above the knee or on the ankle; he has a very irritable heart, quick pulse, short-winded, pulsation at the base, hurts him to go up steps, but no organic disease of the heart, and no murmur at all; has suffered some slight pain in the chest. This young man, with several of his companions, a few weeks ago, started out to run one-eighth of a mile—a foot race for this distance, and, he says, his "wind" gave out before he had gone more than a few rods, and since that time he has been troubled more or less by this peculiar clumsiness or stiffness of his limbs. When I made the first examination I found him wearing a suspensory bandage, he also had a very large bubo on the left side. Before I examined him I had a suspicion that it was specific trouble, and do not now think there can be any doubt about it. It is one of those cases, which, if it goes on for a while without treatment, would be classed "locomotor ataxia," and some man who understood his business treating it properly, the case would be reported as cured of locomotor ataxia. It

has every resemblance to locomotor ataxia in the absence of the patella reflex, although this might occur in other troubles. I do not think it is necessary to look for any other cause than specific infection, and I believe specific treatment is clearly indicated.

DISCUSSION.

DR. A. M. CARTLEDGE: I would like to see this boy go without specific treatment for ten or fifteen days; I cannot help believing that there is a traumatic element in the case. I fail to locate the specific lesion in the phenomena observed. In the general symptoms I do not see anything indicating syphilis; the oedema and hypertrophy of the muscles might be accounted for by simple trauma. I believe that absolute rest with probably some local application to his limbs would be the most rational treatment.

DR. A. M. VANCE: I believe the last case is undoubtedly one of cord trouble. I do not think the effort he made had anything to do with it. The oedema could easily be accounted for by the rigidity of the muscles. In fact the oedema signifies nothing; it is not uncommon to see that much oedema in a perfectly healthy man, especially one who stands up a great deal. I believe that the great majority of the cord lesions simulating locomotor ataxia, are specific.

DR. J. M. RAY: In regard to the eye symptoms in these cases—I have under observation for some time, three cases of one-sided midriasis that are peculiar. The first time I saw these three patients was about six years ago, soon after I came to Louisville. They all had one-sided midriasis and one-sided ciliary paralysis. I have watched all three of these cases, carefully observing all the symptoms. One of them at that time had absolutely complained of nothing; now he is a confirmed locomotor subject. When I first saw him he had no evidence of locomotor ataxia at all. Another one in the last eighteen months has been suffering from what he says is sciatica; has been having pains up and down one leg. For this his doctor has been using a strong galvanic current. The third one was in my office a few days ago, and I questioned him pretty closely, but he denied having any pain at all. However, he did state that after he had stood on his feet for a while, when he started to walk his feet felt like

they were padded or cushioned. I believe this will develop into locomotor ataxia. All of these patients are between thirty and forty years of age; I saw them all about the same time, and they all absolutely deny any specific trouble.

DR. J. B. MARVIN: In my experience I have only met with two cases of locomotor ataxia in which there was a joint lesion. I believe that these cases may be very insidious in their development, and may develop ocular symptoms very early, like those mentioned by Dr. Ray. I have one case under observation now which I have been watching for about fifteen years. The first symptom that attracted my attention was the condition of his eye; contracted; permanently fixed pupil. He went on this way for a long time without developing other symptoms, until two years ago when he began to have symptoms interfering with his locomotion, that is, his equilibrium, pain in the legs, staggering walk, etc., etc. He has improved greatly under iodide of potassium. There was no history of syphilis in this case.

A CASE OF MALINGERING.

DR. A. M. VANCE: I would like to mention a case: Two years ago Dr. Mathews asked me to see a patient with him, a young woman in this city who claimed she had chronic constipation; that sometimes she would not have an evacuation of the bowels for six months. Her father and mother both corroborated this statement. She looked like a moderately well nourished woman, brown skin, good color. Dr. Mathews and myself put her under chloroform to see whether there was an accumulation of fecal matter in the bowels and examined her by palpation, but could not find anything. We then injected into the bowels a large quantity of water, under chloroform, after which there was only an ordinary evacuation. I am absolutely sure that the bowels contained no more fecal matter than in a person who has an ordinary evacuation every day. I believe that this woman was deceiving her parents, and that they were perfectly sincere in their belief that she only had an action of the bowels once in six months. I believe that she had an evacuation every day. While under chloroform we thought she was dead because of a cataleptic spasm which came on.

DISCUSSION.

DR. A. M. CARTLEDGE: I treated this patient in a violent attack of facial erysipelas; she made a good recovery, and there were no symptoms indicating a disturbance or irregularity of the secretions.

FURTHER REPORT OF CARE OF SARCOMA OF UTERUS.

DR. C. SKINNER: I would like to hear a continued report of the case operated upon by Dr. Vance recently at the Infirmary for supposed sarcoma of the uterus.

DR. A. M. VANCE: The patient in question has made an excellent recovery. It has since developed that the section shown upon slide of the microscope, which was supposed to have been secured from the horn of the uterus, was taken from the fallopian tube, or, in any event, from some portion of the specimen remote from the horn of the uterus. If it was sarcoma it was evidently all removed, as there has been no recurrence. The woman has menstruated twice since without pain, which had not been the case for twelve years prior to the operation.

MIGRATION OF A LIGATURE.

DR. C. SKINNER: I want to report a case showing how a ligature will migrate. In June last I operated upon a woman removing a tumor about the size of a large cocoanut, took out the uterus, tied off the ovary on the other side, putting on a double ligature—Tait ligature—treating the pedicle extra-peritoneal. The wound healed up very nicely and the ligature to all appearances was absorbed. The woman has been perfectly well ever since. About two weeks ago she brought to me a thread that had come out of this old scar. It had opened slightly afresh, discharging this portion of the ligature. I know it was the pedicle ligature from the way it was tied. The wound again healed and there has been no further trouble.

AMPUTATED HIP—CONTINUED REPORT.

DR. A. M. VANCE: Some time ago I reported the case of a boy whose leg was amputated at the hip. I would like to make a continued report of the case, as it is a very remarkable one. This boy's history was about as follows: He had hip joint disease coming on when he was about ten years old—there was rapid for-

mation of pus with abscess in Scarpa's space. At the time of opening, upon the introduction of the finger, it was found that the tissues between the femoral artery and the abscess were very thin, and we did not put in a drainage tube fearing that sloughing would take place. About a month after opening the abscess and after running a very septic course, early one morning the femoral artery ruptured spontaneously. The leg was amputated at the hip forty-eight hours afterward as the foot was gangrenous. Operation was done very quickly, the patient being on the table but a few minutes, but his condition was such that his recovery was doubtful. About two months after this he had an attack of double pneumonia; he was still in a very hectic condition, and very little recuperated from the state of depression he had already arrived at and looked as if he was going to die shortly, but the crisis came after about three days. He recovered from the pneumonia, that is the right lung cleared up very well, but the left side of the chest remained dull, the heart beating over to the right side, and we soon found that he had an immense accumulation of fluid in the left chest which was tapped three times. Three and one-half pints of fluid removed the first time; two pints the second and two pints the third time, a pint of which was pus. By this time he was getting pretty shaky again, and I determined to give him another chance, so excised the eighth rib about a week after the last tapping. The cavity was thoroughly washed out with hot water and two large drainage tubes inserted. In washing out the chest, it was done very thoroughly, throwing the water in through one tube which came out of the other, and with each inspiration and expiration it would work like a force pump. The tubes were allowed to remain in for about ten days, when they were removed and a pledget of gauze inserted into the cavity; this was also removed in a few days and the wound healed perfectly.

I think it is quite a remarkable case, the patient going through two grave operations and double pneumonia inside of three months.

DISCUSSION.

DR. A. M. CARTLEDGE: I have recently had several cases of empyema, which have been operated upon by resection of a por-

tion of rib. One case was particularly interesting in that the matter discharged through a sinus in close proximity to the pericardial sac. The patient has done very nicely and the tube will be removed to-morrow or next day. I would like to ask Dr. Vance what method was employed in amputation at the hip joint to control the bleeding.

DR. A. M. VANCE: The artery was already tied owing to spontaneous rupture. I read a little paper the other day at the Southern Surgical and Gynecological Society making a plea for more rapid surgical work. I will state that in the amputation at the hip which I have just reported, the operation was done and the boy back in bed in less than nine minutes.

I believe that two or three minutes more would have caused his death. Resection of the rib was done in seven minutes; of course this is a much easier operation than amputation at the hip.

DR. J. B. MARVIN: Bearing upon Dr. Vance's case: The question has often arisen whether there would be any depression after resection of a portion of rib in cases of pleuritic trouble. I have recently seen several of these cases, in all of which there seemed to be perfect restoration of the lung and no depression. From the external appearance you would never know that a piece of rib had been removed, and the pleuritic effusion evacuated, except for the existence of the old scars.

DR. A. M. CARTLEDGE: I would like to ask Dr. Marvin if he does not believe all of these cases of pleuritic effusion, whether purulent or otherwise, are microbic in origin?

DR. J. B. MARVIN: Yes.

DR. A. M. VANCE: In all the cases I have had there has been perfect restoration of the lung.

DR. J. E. HAYS: Is it necessary always to remove a portion of rib to bring about drainage in these cases?

DR. A. M. CARTLEDGE: I believe that in seventy-five per cent of the cases it will be found necessary to resect part of the rib.

DR. J. E. HAYS: I remember a case I had while I was *internes* at the city hospital; an incision was made in the seventh intercostal space, a drainage tube inserted and the cavity thoroughly washed out with carbolyzed water. The patient made an excellent recovery. It never became necessary to excise the rib. Before the operation the patient was almost unconscious. Chloroform was not administered.

Correspondence.

MEDICAL LEGISLATION AND MEDICAL EDUCATION.

S. S. TOWLER, M. D.
PENNSYLVANIA.

To those who believe in the dignity of the profession and strive to maintain it, the efforts now being made "to advance all along the line" in medical education, are most comforting. The candid admission, that Medical Education was not what it ought to be, and that ignorant and incompetent "graduates" were each and every year being turned out by the hundreds, was the first step in the right direction. I say the first step, because it is impossible to reform either the individual, class, or community, until they are first, willing to admit that the wrong exists and realize it. The next step taken was equally important and encouraging, viz., the recognition of the fact that it was one thing to object and find fault, and an entirely different thing to do better.

We have medical colleges east and west, north and south, that we are justly proud of, as we also are of the fact that the leaders in the American profession are the peers of any in the world. Three and four year terms, "Clinics," and "Poly-clinics," practical teaching and bedside knowledge, with the more rigid requirements for matriculation are great steps forward. How the "old man" sighs, as he thinks of what he might have been with these advantages in his early days. Every man who loves his profession, honors the professors and trustees, who have stepped to the front, and propose "to fight it out on this line." What a pity it is that these efforts can be and maybe; yes, will be, to a large extent, rendered unfruitful for years to come, owing to the cupidity of other professors and trustees, and the indifference of the public. The one class, those colleges that will not march forward, only see in the more stringent requirements of the better colleges, increased prosperity for themselves. They know that the same class of students who fill their seats now will continue to come, and the more readily on account of the longer terms and more strict requirements of the other colleges. The man who simply wants "to get through" will still

go there and he knows that he will get through. "Ten months and I'll be a doctor," is a tremendous temptation for the young fellow who despises the plow, work shop and the mill. "Ten months," why he can't "graduate" on either the farm, or in the work shop, or mill in that time, and he knows it. A young fellow asked me not long ago, "Doctor how long does a young man have to study before the Presbyterians will ordain him?" "About seven years," I replied. After a long silence he said, "I guess I'll be a doctor, there is —, only two years ago he was driving a meat wagon, and look at him now. He is "Mike with Pete's boots on." Perhaps there was something in the meat business that specially fitted him for the profesh, eh!" It was a very sickly smile that came on my face at the joke. "Ten months is bad enough in itself, but when even the ten months are put in a desultory manner, as they often are, what kind of a graduate can we expect?" It is always with a feeling of pain and sometimes reluctance that I write or talk on this subject, for no one can know more about the hardships of the poor, young beginner than I did. I sympathize deeply with the young fellow that leaves college with almost his last dollar gone and whose only hope for another is in an early and timely patient.

After twenty-five years' practice I can look back and see how much better it would have been for me, had entrance into the profession been more guarded though it would have been very hard on me at the time. I could not see it then—I know it now—and so does every candid practitioner of years' experience.

Yet in those days I think preceptors took more interest in students than they do now. I know I owed to a preceptor all the practical knowledge I had when I began practice. He took me with him to see his cases and would patiently explain the situation. He would stop the buggy in the woods where he gave me lessons in medical botany. It was very pleasant and very practical, equally practical, but not so pleasant was sitting on the back office floor, with a big iron mortar between my knees, pounding green roots and powdering assafetida. Those were not the days of "elegant pharmacy." I have dropped into this personality because in the correspondence occasioned by the

publications in this journal of my paper on "Medical Legislation," has appeared in effect this, "your position and arguments are all right but its hard on the young fellows." I know all about that side of the question and my present conclusion is simply one of conviction after years of practice. I believe from my own experience, as well as from the logic of the situation, that it is very much better for the student, hard as it may now appear to him, to put in four years instead of two, and infinitely better for those amongst whom he will practice. Besides this, practice is not to-day what it was then. He is a bright student and a worthy graduate, who at the end of three, yes, four years, is fully up with the times in these days. It is impossible, with all the meaning that the word implies, for a young fellow to-day to leave a common school and with the ordinary common school education to enter a medical college of the advanced grade, and at the end of four years, come out, up with, and abreast of the times. Impossible, because the foundation is not there to build on and he will have no time to spare undermining the superstructure in order to rebuild the foundation. It will be too late to begin taking out the wooden posts to put in a stone wall. Advanced medical knowledge of this day is simply a stupendous study. None know it better than those of by-gone school days, who are trying to keep in these latter days, at least within hailing distance of the new discoveries and ideas. All this, however, is of no consequence to a class who long to pose as "professors," and the class who want to pose as "doctors." With them two terms of five months each will still be long enough.

Then that other class, the indifferent public. Indifferent, because they do not realize the situation; indifferent, because so many in the profession are indifferent; indifferent, because to them "a doctor" is "a doctor," regardless of his qualifications. This public indifference is more than astonishing when one thinks of what it involves. Then there is the consequent factor of this indifference, ignorance, as to the needed qualifications. Yet there is no subject of which the average citizen, male and female, assumes to know so much as that of medicine. Consciously or unconsciously, they assume to know, as witness the dismissal of worthy

medical attendants and employment of the quack without reason or even inquiry. It is perfectly safe to say that not only us country physicians have our patience tried with this sort of thing, but that not a prominent city physician but has had patients leave him and go to an ignorant pretender. It is not only the ignorant public that do this, but judges, lawyers, merchants, and sorry I am to say, many clergymen.

This reminds me of a funny incident. Two years ago I was sitting in the almost empty Senate chamber at Harrisburgh conversing with that prince of good doctors, Prof. John B. Roberts. We were going over the "Examiner's Bill" together, and Dr. Roberts was in deep earnest. It is only justice to him to say that he instilled a good deal of his enthusiasm into me. As the good doctor was thus laying it earnestly down a prominent member of the "House" passed by. On my return to the "House" side of the capitol, this gentleman who was always jolly, said to me, "Who is the distinguished looking friend over in the Senate?" I replied, "Dr. John B. Roberts and he is very much in earnest over the Examiner's Bill." "Ah!" said my friend, "probably some quack has coppered one of his best patients." I laughingly assured the honorable gentleman "that that was *not* one of the arguments that the doctor had advanced."

Now what is to be done with these three classes. The professors "of Cupidity," the anxious "to get through" student, and the indifferent public. Can the professions or the public afford to wait until the people are educated up to the *discrimination* process? Certainly not. When the educated layman has reached that point, we must still remember in the interests of a common humanity, that "the poor ye always have with you." The poor, the ignorant poor, whose father, mother, son, daughter, baby, is just as dear, and whose life is just as precious to them as those of the learned, or "better class" are to them. It were a shame on our manhood to leave these victims to the pretender.

The remedy is *Medical Legislation*. That, and that alone, provides the remedy and as it is for public protection, it is the natural and rational remedy. While the State Medical Society is bend-

ing its efforts to secure this public protection, those colleges that have adopted a three and four year course, can not afford to stand idly by. To make the advance effective, they must like good commanders, protect the rear. It will not do to simply pass a faculty resolution of approval. "Cordial Sympathy" effects nothing. The other side won't pause, passing and monkeying with resolutions. They will be and are *at work*. The faculty of every three course college should at once get in line, and communication with Dr. McCormick, chairman, and Dr. Roberts, secretary of the State Committee.

Gentlemen of the Pennsylvania Regular Faculties,—Country Doctors can only contribute their mites, you can "pour out" of the welath of your brains and influence. Besides your personal influence you have behind you, in *your Alumni*, a powerful army. Call these to the front to battle for the honor of their Alma Mater and the advancement of the profession, and do it now.

The *Pittsburgh Medical Review*, of December, says: "The merely passive approval of the friends of the bill is more to be feared than the activity of its enemies." That is the situation exactly. "Whoop her up for all your worth" is neither elegant or professional, but it expresses what needs to be done very fully. The profession can not afford to pass, or attempt rather, to have bills passed by *Legislative tricks*. The bill that will be put before the Legislature is worthy enough to pass on its merits without change or amendment. The State can have nothing to do with "Sect" in medicine, any more than in Theology. That position once taken and the Thomsonian, the Hydropathist, the Vitapathic, and every other "pathic," and "ism" would have a right to state recognition. The proper thing to do is for the profession, as a whole, to stand by the State Society's bill, as *it is*, and thus work for public protection and honor ourselves.

Removal of the diseased part of the ovary, when not more than half of it is involved, is now advocated and practiced by advanced gynecologists. The remaining part of the ovary is neatly stitched together with fine sutures and good results are reported.—*Ex.*

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THE MEDICAL AND SURGICAL REPORTER.

SATURDAY, DECEMBER, 31st, 1892.

MEDICAL LEGISLATION.

Of late THE REPORTER has devoted considerable space to Medical Legislation and Medical Education. No apology need be offered for this in view of the great and widespread interest that has been aroused concerning these questions.

Of direct interest to the profession in Pennsylvania, and incidentally to all medical men, is the renewed attempt to obtain for this Commonwealth such legislative action as will compel those seeking to practice within its limits to furnish proof of at least ordinary capability.

An unsuccessful effort was made to obtain such enactment of the last legislature.

Various explanations of its failure have been offered, *class legislation* being the general rallying cry of those opposing the bill presented. In reality the probable cause of failure was a lack of combined effort on the part of the great majority of the profession interested, while there was no such lack on the part of the opponents.

The failure of this last effort may prove eventually most fortunate for the general cause of higher medical requirements. Certainly it has tended to arouse the profession, to crystallize its opinion and to unite its effort, to secure the desired end.

Whatever objection might be raised to the bill in its present form, it certainly cannot be said to militate against any individuals or interests, theories or practices which it is not directly and confessedly intended to abolish.

Our friends who believe in peculiar or specific systems of medicine and practice, accordingly, can no longer cry *unfairness* or *persecution*, for the bill designedly omits any test that would discriminate between conflicting theories of practice.

Indeed, the most influential and liberal of the so-called sectarian organs deliberately deprives any disposed to cavil of all hope of sympathy or support from the intelligent mass of men for whom it speaks. We take pleasure in presenting the following, which will appear as an editorial in the January number of the *New York Medical Times*:

PROPOSED STATE BOARD OF MEDICAL EXAMINERS IN PENNSYLVANIA.—STATE RECIPROCITY.

Another attempt will be made this winter to establish a State Board of Medical Examiners in Pennsylvania, and we sincerely trust that it may be successful.

The copy of the bill before us provides, among other things, that the Governor shall appoint nine persons, graduates of some legally chartered college having the power to confer medical degrees, with ten years active practice, no two of whom

shall be resident of the same county and none of whom shall be a member of the faculty or staff or any medical school or university.

"SECTION 6. Provides that the said board shall examine all applicants for license to practice medicine or surgery in this Commonwealth who are properly qualified according to the provisions of section seven of this act, and no one shall be excluded or rejected on account of adherence to any special system or school of practice. It shall hold two stated meetings in each year, one at Pittsburgh and one at Philadelphia respectively, and may hold special meetings at such times and places as it may deem proper. All examinations, when practicable, shall be conducted in writing, and all examination papers, together with the reports and action of the examiners thereon, shall be preserved among the records of the said board for a period of five years, during which time they shall remain open for inspection at the office of the said board.

"SECTION 7. Any person on paying ten dollars to the secretary of said board, and on presenting satisfactory proof of being over twenty-one years of age, of good moral character, and of having received a sufficient preliminary education as defined by said board, and diploma from some legally incorporated medical college or university having authority to confer degrees in medicine, shall be entitled to examination by the said board, and in case of failure, at any examination shall have the privilege of subsequent examinations without the payment of an additional fee. Each applicant who shall have passed a satisfactory examination shall receive from the said board under seal a license to practice medicine and surgery in the Commonwealth of Pennsylvania, and the said board may at its discretion grant licenses without examination to persons holding licenses from similarly constituted boards of examiners or boards of health in other States.

"The applicants shall be examined in anatomy, physiology, chemistry, pathology, hygiene, toxicology, differential diagnosis, surgery, and obstetrics; and each applicant, upon receiving from the secretary of the board an order for examination, shall draw by lot a confidential number, which he or she shall place upon his or her examination paper, so that when said papers are passed upon by the examiners the latter shall not know by what applicant said papers have been prepared, and upon each day of examination all candidates shall be given the same set of questions."

It will be observed that the only reference to drugs is in respect to their *toxic* effect, and thus all theory as to their *modus operandi* and the possibility of danger of prejudice on the part of examiners is avoided.

We do not see what more could be asked by any school of medicine than this, in the way of protection of its rights.

There are good honest men on both sides of this controversy, men to be trusted, but they have no confidence in each other. Each party feels that the other is trying to gain improper advantage, and how to get over this complication is the question. If the leaders on both sides could know each other better, it would certainly tend to promote confidence and harmony. If the homœopaths could be satisfied that their scheme of therapeutics was not in danger, they would be less suspicious.

The dominant school would be satisfied, no doubt, with the wiping out of all sectarian designations.

The records show 8,248 physicians in the State. Of these, 6,240 are denominated "regulars" for the sake of comparison; the secretarians number 1,075; those practicing without diplomas, 933. The homœopaths claim 691, and the eclectics, 293.

It must be evident to any one that a board consisting of three members from

each school, would not be justified by the above ratio.

It is well known what the result would be were there three distinct boards, and least qualified students would get through the weaker board as was the case in this country some years ago.

It is the wish, so far as we know, of all medical men in good standing, who have the best interests of the public welfare uppermost, that each State shall have a Board of Medical Examiners before whom all candidates shall be examined, and the method to bring about this result should be made as simple as the circumstances will allow, and each school should be anxious that no injustice is done to any.

NECESSITY OF STATE RECIPROCITY.

The next thing to do is to harmonize the working of these different boards in the various States, upon reciprocal grounds.

The reciprocity should be arranged between all States where the requirements of the law respecting examinations are similar.

It is an inconvenience and an injustice, to ask a qualified practitioner in one State to qualify in another, where he happens to be sojourning, before he can prescribe for a patient. The proper thing would be to have a National Board composed of delegates from the several States, where the different interests would be harmonized. It would subserve the end in view if the license to practice in a State of this Confederation, would be registered in each of the other States with whom the reciprocity exists.

Let us take, for instance, the States of New York and New Jersey, where it is almost a necessity for the practitioners of one State to practice more or less in the other, for various reasons.

As the laws are at present in these two States, the physician who prescribes for a patient out of his own State is liable to arrest in the other State for so doing, and to fine and imprisonment.

In the case of New Jersey, the law has resulted in keeping people away from it in summer, because their own physicians in New York would not take the risks of coming to them in case of illness.

Both of these States now have Examining Boards with requirements nearly identical, so that license to practice in one may be made to cover both, if the authorities agree to it, and this illustration shows how the principle may be made to apply to all States in the Union where similar conditions exist.

A bill will be presented to the next session of the Legislature in this State, with the hope that these unnecessary annoyances to the profession may be mitigated by suitable reciprocal provisions.

It is hoped that every practitioner in the State will see that it is for his interest to promote this movement, and that he will explain the subject to his representatives in the Legislature, that they may be prepared to vote intelligently whenever the bill shall come to be acted upon.

Our friends in New Jersey should make a similar move at the approaching session of the Legislature in that State, then, with two States working together on the reciprocal plan, it will not be difficult to unite others as fast as they adopt the plan of State Examination.

Never poultice the eye unless you want it to rot out. In case of sty or chalazion, and the globe of the eye is not involved, the lids may be poulticed over the swelling. In the beginning of those inflammations, hot water, applied every two or three hours and from five to ten minutes at a sitting, will often abort suppuration.

Incontinence of urine is relieved by beladonna when the following conditions are present, viz.: relaxation of the sphincter vesicæ or irritability of the mucous membrane of the bladder. From five to fifteen drops of the tincture or from three to ten drops of the fluid extract should be given at bed-hour. Children require large doses.

—*Ex.*

Translations.*

By MARIE B. WERNER, M. D.

Fatal hemorrhage during the 9th month of pregnancy owing to the premature separation of a normally inserted placenta. M. Maygrier (*Bull et Mimoires de la Soc. Obstet. et Gynec. de Paris*, 8, '92). Patient had previously given birth to three children; last period Sept., 1891, normal pregnancy. On June 6th while the patient was seated on a bidet giving herself an injection, she was found by her nurse in an unconscious condition and deathly pale. She was at once placed in bed when it was found that a hemorrhage from the vagina caused the weakness. Twitchings of the face and extremities took place; the vagina tamponed and an abdominal compress applied. In spite of subcutaneous injections of stimulants, etc., the patient never regained consciousness and death occurred one hour after the hemorrhage set in. The child being dead Cæsarean section was not performed.

Post-mortem examination disclosed as cause of the hemorrhage a separation of the placenta of about the size of an ordinary saucer; all other organs were in good condition. Rare as this may be, it is a complication which must always be born in mind in cases of sudden death in pregnancy.

Pregnancy in a double uterus. E. Rossa (*Wien Klin. Wochen.*, 35, 1892). The patient during her 7th month of pregnancy was taken in labor, the midwife unable to find the os, sent for a physician who found the cervix high up, the uterus normally enlarged and to one side of it, in the abdomen, a tumor could be felt which contained the fœtus. The doctor suspected a tubal pregnancy with threatened rupture and sent the patient to the hospital. An examination showed the uterus to be between seven and eight months, vertex presenting. Vaginal examination reveals a rounded tumor, which is felt more to the right of the pelvis; to the left and posterior, the finger reaches up between the tumor and vagina wall, to a normal but hard cervix. On the left side of the presenting tumor the finger feels a small opening, one cm. in diameter,

through which the membranes can be felt. This opening enlarges itself with the uterine contractions. Rupture of the membranes is followed by birth, after two decided pains. Delivery of the placenta was slow, and accomplished by manual compression. A subsequent examination showed a relaxed fold in the posterior wall, which proved to be the partition, between the two vagina.

The puerperium was normal, on the third day there was a discharge of a gray reddish membrane which proved to be the decidua—of the left uterus. This was without doubt a case of double uterus and vaginae. Until now there have been nine cases of this kind reported, three have been pregnant, this making the fourth, and the tenth in all.

Post-partum examination revealed both uteri to be entirely separate. The fundus of each being separated from each other six to eight cm. The formation of the body is spindle-shaped, the adnexa on both sides are normal; the cervixes are also entirely separate. Both uteri are normally developed and normal in their functions. The first pregnancy occurred in the left uterus as shown by the cervix and was normal throughout. The second pregnancy occurred in the right uterus. The history of menstruation was normal at intervals of every four weeks. (In a case reported by Kubasson's there were intervals of fourteen days between the menstrual epochs). The vaginae are double, but the right side ended in a blind pouch behind the right labium minor. The partition wall must have been perforated before puberty, otherwise the normal functions of the uterus of the right side would have produced tarmatokolpus. The remnants of this septum may in any future pregnancy become an obstacle during labor, as it was, in a measure, in this present one by arresting the birth for a time. C. Braun has advised entire resection of such a septum. This was, however, not necessary in this case since the existing opening in the septum was easily enlarged by the examining finger.

Death in a child of ten weeks following an incomplete attempt at vomiting reported by Prof. Dr. Demme, of Bern, (*Wien. Med. bl.*, 12, '92). The child was fed on cow's milk and frequently vomited large masses of coagulated milk which had

*Translated for MEDICAL AND SURGICAL REPORTER.

a sour odor. A mixture of Sod. Bicarb. 2:100 Ag. Dest. was ordered, a teaspoonful to each portion of milk. This produced the desired results, the vomiting ceased completely, whereupon the mother discontinued the medicine. One morning, however, she found the child dead. She had placed it into bed the night before apparently well after having fed it liberally on milk. The lips of the child were tightly clinched, of a dark bluish-red hue, cheeks and nails were bluish. An autopsy revealed the entire œsophagus up to its pharyngeal opening filled with a solid cheesy mass. This was also found pressing tightly against the epiglottis almost closing it hermetically. The pericardium and pleura were covered with numerous punctated hemorrhagic spots. All other organs were normal.

Without doubt the child strangled in its efforts at vomiting. This to the author's mind, explains the cause of some of the sudden deaths without apparent reason, which so frequently appear in literature, and therefore thinks it wise to caution mothers to watch their children sometime after having fed them; and if efforts are made at vomiting to take it up and lay its breast over her arm and gently beat its back.

Phenolsalyl is a mixture of Acid Carbol. 9 parts, Acid Salicyl. 1 part, Acid Lactic 2 parts, Menthol O, 1 part, dissolved by heat, soluble in glycerine, moderately so in water. This mixture was tried in Pasteur's institute and is supposed to possess greater antiseptic properties than the single ingredients. (*Deutsch. Med. Ziet.*, No. 98, 1892).

The antidyspeptic powder of Dujardin-Beaumetz.

R Bismuth Salicyl.....
Naphtholaa 5, 0
Carbon Pulv. et Larat.....10, 0

Mix.—Div. in part, arg., No. 20.

Sig.—One powder before each meal. If eructations or flatulence are present due to cancer of the stomach. Should diarrhoea be present he prescribes.

R Bismuth Salicyl.....10, 0
Saliol et. Sod. Bicarb.....aa 5, 0

Mix.—Div. in part 20.

Sig.—One powder before meals.

(*L'Un. Med.* 115, '92).

Supra pubic cystotomy in children. Dr. L. P. Alexandrow (*Archiv. of Klin. Chirurg.*, 41) reports twenty-six cases of sectio alta done in the last two years at

the surgical department of St. Alga's Childrens' Hospital in Moskau. Of the twenty-six there were twenty-three done on children between the ages of two and a-half to seven years. Two were almost ten years and one five years. The operations are divided into three classes. The first class comprises two cases in which there was drainage from the bladder, complicated by fever, pyelites and hæmaturia. In the second class of sixteen cases the bladder was closed and the perivesical space was drained. Healing was complete between three to eighteen days. The third class embraces eight cases in which the entire wound was closed by the *etagennaht* or sectional suture. Of these eight cases, seven healed by first intention. One had vesical hemorrhage making it necessary to reopen the wound, and union was complete only after the 31st day. The materials used for sutures were silk and catgut.

Abstracts.

TAX ON QUACKS.

The recent suggestion of the Secretary of the Treasury that the tax on alcohol be increased fifty cents per gallon in order to raise more money for the increasing expenses of the Government seems to have met with a favorable response in some quarters, and the question of tariff and taxation will no doubt be considerably discussed by Congress in the near future.

In this connection the wisdom of putting a heavy and permanent tax on all forms of nostrums and quackery will at once commend itself to all wise legislators who are working for the public good. A stamp tax of this kind, say twenty-five per cent., on every form of secret or proprietary medicinal preparation of every kind, whether sold by the retailer, proprietor, manufacturer, or by advertising quack specialists, would be no hardship to the public, as it would in no wise affect the retail price of these articles. All such manufacturers could easily afford to give the Government twenty-five per cent. of the retail price and still have a very handsome profit left, as their net profit is rarely less than five hundred per cent., and often very much more.

Legitimate preparations of the Pharmacopœia and other standard preparations where the complete working formula is public property should be exempt. But as the success of quackery depends on secrecy and mystery, and as these two conditions enable unscrupulous persons to get a dollar for a few cents' worth of a simple remedy, it will be seen that there would be no injustice to any one if a good fair tax were put on the business.

If the Government went still further and required all nostrum and secret medicine manufacturers to pay a big license, and place on record open to public inspection a sworn statement of the exact composition, together with a complete working formula of each preparation, much good would result. And if, like insurance companies, they were also required to furnish heavy bonds or make a special deposit, which could be forfeited under proper restrictions, provided their medicine did not do all that was claimed for it, the public would be still better protected both in health and pocket, and no injustice would be done to the honest manufacturer of articles of real merit.

There is no good reason why the Government should not place the nostrum business on the same basis in its Internal Revenue Department as the manufacture of whiskey and tobacco. Analysis of these preparations should be made from time to time, and heavy penalties be imposed if they vary from the sworn formula on record, or if any dangerous drug like morphine is being used.

England, which is said to be a free trade country, taxes the nostrum business heavily, and derives a large and growing revenue from that source.—(To appear in January number of *New York Medical Times*.)

NERVOUS DISEASES IN LOW RACES AND STAGES OF CULTURE.

Among the errors which have been diligently disseminated by physicians who lacked ethnological information is that which claims that diseases of the nervous system, especially those of a hysterical character, have greatly increased with the development of civilization, and are most common in the races of highest culture.

Both assertions are erroneous. Those intelligent travellers who give the sound-

est information on this subject report that in uncultured nations violent and epidemic nervous seizures are very common. Castren describes them among the Siberic tribes. An unexpected blow on the outside of a tent will throw its occupants into spasms. The early Jesuit missionaries paint extraordinary pictures of epidemic nervous maladies among the Iroquois and Hurons. The Middle Ages witnessed scenes of this kind, impossible to-day.

In a late number of the *Journal de Medicine*, Paris, Dr. De la Tourette points out the frequency of true hysteria and hysteroid seizures in the Black race, among the Hottentots and Caffirs of East Africa, and among the natives of Abyssinia and Madagascar. They present frequent cases of classical hysterical attack and occasional epidemics of choreomania, affecting both sexes. A negress of the Soudan was lately a patient in the celebrated clinic of Dr. Charcot in Paris, and displayed the symptoms characteristic of neurosis. Civilization, so far from increasing this class of maladies, is one of the most efficient agents in reducing them in number and severity. When it is freed from certain elements not essential to it, especially religious excitement and competitive anxieties, it acts decidedly as a preventive.—DR. BRINTON, in *Science*.

Medical journals are the educators of medical men. As the *California Medical Journal* says, we know of nothing pertaining to medical literature, more interesting than the reading and comparison of medical journals. Some are devoted to surgery, some to medicine, some to hygiene, some to gynecology and some to all these various branches. In some we can see the careful diagnosis, the guarded prognosis and judicious treatment, begotten by years of painstaking conscientious work. Others are filled with the writings of enthusiastic theorists. In others we see the careful, conservative work of the experienced surgeon, and in others the work of the careless operators who are ever ready to operate, regardless of present conditions or future consequences. Any one who will read a half dozen different journals, and give their contents some thought may gain a valuable lesson not alone from the intrinsic value of each, but more especially from the comparison or contrasting of thought.—*Ex.*

NEWS AND MISCELLANY.

ALPHABET OF PROVERBS.

Denying a fault doubles it.
 Knavery is the worst trade.
 Foolish fear doubles danger.
 Boasters are cousins to liars.
 Richest is he that wants least.
 Modesty is a guard to virtue.
 Upright walking is sure walking.
 Quiet conscience is quiet sleep.
 You never lose by doing a good act.
 The boughs that bear most hang lowest.
 He has hard work that has nothing to do.
 One hour to-day is worth two to-morrow.
 Envy shoots at others and wounds herself.
 Zeal without knowledge is fire without light.
 Proud looks make foul work in fair faces.
 A grain of prudence is worth a pound of craft.
 Learning makes a man fit company for himself.
 Confession of a fault makes half amends.
 Not to hear conscience is the way to silence it.
 Virtue and happiness are mother and daughter.
 It costs more to revenge wrongs than to suffer them.
 Wise men make more opportunities than they find.
 Small faults indulged are little thieves that let in greater ones.—*The Tex. Health Jour.*

PERFUMES AND THE SENSE OF SMELL.

The olfactory sense is followed by effects of different kinds of intensity from those of sight and hearing, and may be accompanied by a kind of poisoning. The old medical books are full of stories of it. There are those of a girl killed by the exhalations of violets; of a woman seized with a violent headache from sleeping on a bed of roses; and of a girl who lost her voice by smelling of a bouquet. Ancient medicine attributed curative properties to perfumes, particularly to those of the rose, musk, and benzoin. The intensity of the effects of perfumes makes a rapid succession of sensations almost impossible, for consecutive odors cause a rapid anæsthesia of the senses; on the other hand, if the

times separating two successive sensations are too long, it becomes impossible to combine them, and the anticipated effect is disturbed by strange feelings. In short, smell is rather the complement of other excitation like a melody or a picture. Its function is, nevertheless, very important. By virtue of its volatility it is a valuable prophylactic; by the great intensity of its effects it can bring about salutary modifications of physiological functions, particularly of the amplitude of respiration; and it possesses in the highest degree the luxurious character of every artistic enjoyment. Flavor has an essential part in nutrition; so has touch. Hearing and sight are indispensable to relation with other persons; but smell, necessary to the animal for finding its prey and avoiding danger, has become, under normal conditions, an almost useless sense to man, since the refinements of civilization tend to prevent the production of miasms and the pestilential odors from which he has to protect himself. It is therefore becoming more and more a sense of luxury for civilized man; and that perhaps, is the reason why poets, from the author of the Song of Songs down, have associated all kinds of beauty and joy with perfumes.—*Popular Science Monthly.*

The milk in the cocoanut may be extracted from the following occurring in an article by Dr. N. G. Whipple (Kansas City *Med. Rec.*): A strong point in the code is that physicians avoid giving publicity to their cases through the papers. In most of the appall.—*Med. Rev.*

BOOKS RECEIVED.

[In sending books for notice in the *REPORTER*, publishers are requested, for the information of the reader, as well as for their own advantage, to give the price. This announcement by title will be followed, in most cases, by a review, which will appear at the earliest opportunity.]

Hygienic Measures in Relation to Infectious Diseases. By George H. F. Nuttall, M. D., Ph. D., (Gottengen). New York and London: G. P. Putnam's Sons, 1893. Price, 75 cents.

Manual of Practical Medical and Physiological Chemistry. By Charles E. Pellew, E. M. New York: D. Appleton & Co., 1892. Price \$2.50.

Materia Medica, Pharmacy, Pharmacology and Therapeutics. By W. Hale White, M. D., F. R. C. P. Edited by Reynold W. Wilcox, M. A., M. D., LL. D. Philadelphia: P. Blakiston & Co., 1012 Walnut St., 1892. Price \$3.00.

The Anatomy of the Peritoneum. By Franklin Dexter, M. D. D. Appleton & Co., 1892.

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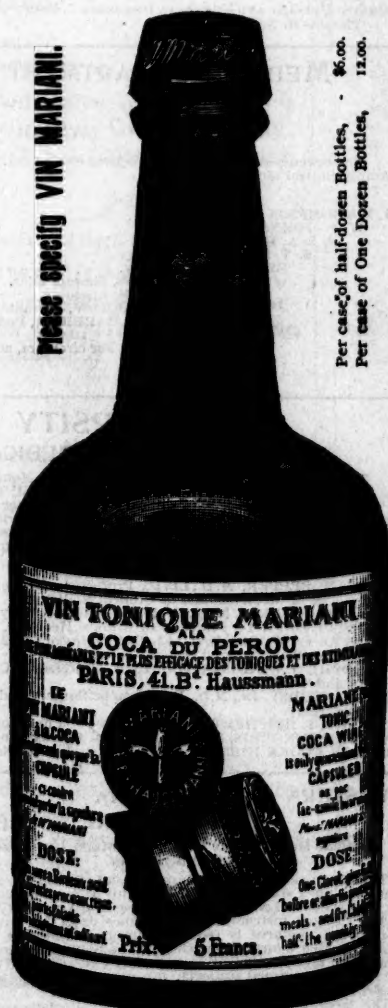
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OBSTETRICS AND DISEASES OF CHILDREN—E. P. Davis, J. Madison Taylor.

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DISEASES OF THE EAR—B. Alex. Randall, R. W. Seiss.
DISEASES OF THE SKIN—Arthur Van Harlingen, J. Abbott Cantrell.

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Peroxide of hydrogen was discovered and described in the year 1818 by the illustrious French chemist, Baron THENARD. B. W. RICHARDSON, M. D., (*Asclepiad*) says: "In 1860 I made my first report to the Medical Society of London, and, in 1862, I made a second report on the medicinal use of the peroxide. I had by this time used it in two hundred and twenty-three cases of disease, including phthisis, diabetes, anæmia, sub-acute and chronic rheumatism, strumous enlargement of the cervical glands, mesenteric disease, pertussis, chronic bronchitis, chronic laryngitis, mitral disease, and dyspepsia. In epitome of results I drew the conclusions: That in diabetes the peroxide reduced the specific gravity of the urine, while it rather increased the quantity; that in chronic and sub-acute rheumatism is afforded relief; that in valvular disease of the heart with pulmonary congestion it gave relief to the dyspnoea; that in mesenteric disease; and in jaundice it caused an improvement in the digestion; that in pertussis its effect for good was very remarkable, since it cut short the paroxysms of cough, and seemed decidedly to shorten the period of the disease; that in chronic bronchitis it lessened the dyspnoea, and rendered the expectorated matter less tenacious; that in chronic laryngitis it gave pain on being swallowed, and did not appear to be useful; that in anæmia it did not of itself render any service but favored the good effect of iron; that in the first stage of phthisis it caused improvement in the digestion, and in the later stages gave unquestionable and even wonderful relief to the breathlessness and oppression, acting, in fact, like an opiate without narcotism, and assisting oxidation.

In the discussion which followed upon the reading of this paper I was warmly supported in several points by Drs. GIBSON, SYMES, THOMPSON, and GIBB, all of whom had been prescribing the peroxide on the suggestion made in my previous paper of 1860. Dr. GIBB bore special testimony to its value in affording relief during the last stage of phthisis, for which I had recommended it in the case of a member of his own family. But the most important new observation I had to communicate to the Society in 1862 was that in free and frequently repeated doses the peroxide could be made to produce a modified salivation, a fact which led to two suggestions;

firstly, that in the use of mercurial and iodide preparations it was the chlorine or iodine in them which caused the pyalism; secondly, that the peroxide would be a good substitute for mercury and the iodides in the treatment of syphilis.

In testing the action of the peroxide on natural organic structures which liberate oxygen from it, I observed, as related above, that the fluid oxygen causes, in some instances, decomposition of the organic matter. The same fact was observed with abnormal organic material like pus. When pus is placed for observation under the microscope, mixed with the neutral peroxide solution, the phenomena are most interesting. The pus corpuscles are, for a time, driven about as if they were alive. They move in all directions, assume ovoid shapes as they squeeze through masses that may obstruct their course, and after many variations of form and movement come to a standstill, like amorphous matter, dead, so to speak, and entirely disorganized. This effect of the peroxide in destroying pus cells led me very early in these researches to use the solution for the treatment of suppurating surfaces, and with great success."

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DR. THOMAS S. K. MORTON, in an article on the "Treatment of Leg Ulcers," *N. Y. Med Journal*, page 26, July 2, 1892, says: "Next, the ulcerated surfaces are subjected to the powerful but harmless antiseptic action of a spray of full strength (15 volume) peroxide of hydrogen solution. Pouring on of the agent is almost as efficient, but very wasteful. If the spray is employed, however, it is essential to use an atomizer of which every part is made of hard rubber, as the powerful oxidizing qualities of the solution will almost immediately destroy any metallic parts with which it may come in contact. The ulcer, having been thus sprayed until active effervescence ceases, is then gently washed off by a stream of simple water, or by a pledget or mop of absorbent cotton saturated with the same. This carries away all detritus loosened up by the action of the peroxide."

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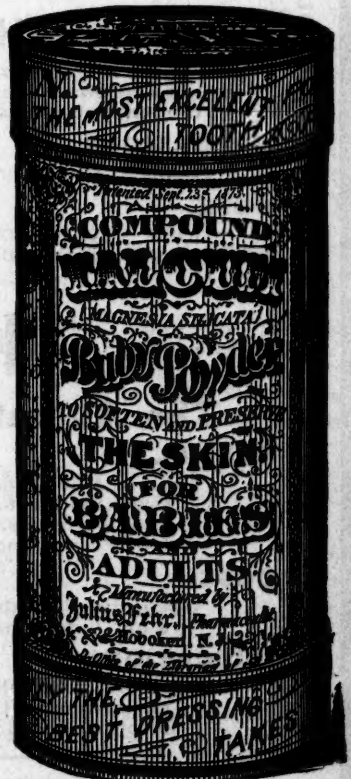
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For Influenza ("la grippe"), Acute, Articular Rheumatism, Neuralgia, Migraine, Pertussis, and all Painful Febrile Conditions whether or not dependent upon a Rheumatic Diathesis. [Pills of 2 1-2 and 5 grs. each, of equal parts of salophen and phenacetine.]

Pil. Terpin Hydrat., "W. H. S. & Co."

Exhibited in Bronchitis, Catarrh, Coughs, Colds, Asthma, and all Respiratory Affections. Unlike terebinthina and some of its derivatives, **no unpleasant symptoms** follow its use. [Pills of 2 and 5 grains.]

Pil. Creasoti, "W. H. S. & Co."

Prescribed for Pulmonary Tuberculosis, Pulmonary Phthisis, and Acute and Chronic Diseases of the Bronchia. It adds to the Appetite and Weight. [Pills of ½ and 1 grain.]

Pil. Phenacetine (Bayer), "W. H. S. & Co."

Administered in All Forms of Fever, Pain, Rheumatism or Neuralgia, and in all maladies in which an Antipyretic or Analgesic is indicated. It is also valuable in Pertussis. [Pills of 2, 3, 4 and 5 grains.]

Pil. Hydrargyri Tannici, "W. H. S. & Co."

Advantageously used in all cases in which Mercury is required. Especially valuable in the prolonged treatment called for in the various forms of Syphilis as it neither salivates nor disturbs the digestive organs. [Pills of 1 gr. each.]

W. H. Schieffelin & Co., New York.

NOTE THE FOLLOWING.

Fluid Forms of Hydrastis.

The reputation of this drug as a therapeutic agent was first gained through its employment in the form of an *infusion*; and in the fifty years following its introduction into medical practice a continuous effort has been made by manufacturers to perfect a preparation which would represent all the active principles of the drug, without the high price of the salts, either alone or in combination.

The most prejudiced writers on *Materia Medica* accord to the late Wm. S. Merrell the largest share of credit in the introduction of Hydrastis preparations, and to the present organization the reputation of being the *largest consumers of the drug in the world*. For more than a half-century Hydrastis has been made a study in our laboratory, and we do not think we exaggerate its importance when we assert that it stands pre-eminent to-day as the most valuable exponent of our vegetable *Materia Medica*.

Fluid Hydrastis—MERRELL.

Is what its name implies—the active, medicinal principles of the drug in natural combination and in a fluid form. It has a bright yellow color, perfectly clear, free from sediment, and with an unmistakable odor of the *fresh drug*.

Fluid Hydrastis is a pure, neutral solution of all the alkaloidal constituents of the drug, rejecting the oil, gums, irritating and offensive resins, and inert extractive matters. The success attending its introduction is the best evidence of its therapeutic value.

Unsuccessful imitations and would-be substitutes are met with on every hand. Preparations said to be "just as good" or "about the same thing," but always "a little cheaper," attest the widespread and growing popularity of Fluid Hydrastis. All such, compared with the latter as to physical appearance or as representatives of the drug, *are condemned*; dispensed in prescriptions, *they are readily detected*; tested therapeutically, they are *promptly rejected* as unworthy of confidence.

Fluid Hydrastis is applicable to the treatment of all irritable, inflammatory and ulcerative conditions of the mucous tract.

This statement of a well known medical writer and journalist has become axiomatic:

"No remedy for physician's use has been received with such universal approval."

Solution Bismuth and Hydrastia—MERRELL.

An invaluable and scientific combination, wherein the beneficial action of the white alkaloid is increased by association with Bismuth. This solution contains 2½ grains of the double Citrate Bismuth and Hydrastia; twenty-five per cent. of which is Hydrastia Citrate.

The cordial reception accorded this preparation marks it as the most valuable combination in the market in which the white alkaloid alone represents the valuable properties of the drug. Used in diseases of the nasal passages, of the eye, of the throat, of the stomach and intestines, of the reproductive organs and bladder it is equally beneficial.

Colorless Solution of Hydrastia—MERRELL.

This is a permanent solution of the white alkaloid, without the addition of any other medicinal agent to modify or increase its action. It is offered without special recommendation to meet the views of a limited number of physicians, with whom the color of the Fluid Hydrastis is an objection. This solution contains in one fluid pint the same proportionate strength of white alkaloid as exists in an average quality of crude root.

See notes above on Solution Bismuth and Hydrastia.

"Merrell's Hydrastis Preparations" are for sale by Wholesale Druggists throughout the United States. Please specify "Wm. S. M. Chem. Co." in ordering or prescribing.

THE WM. S. MERRELL CHEMICAL CO.,

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